Systems of Care
Promising Practices in Children's Mental Health
1998 Series

VOLUME VII

A COMPILATION OF LESSONS LEARNED FROM THE 22 GRANTEES OF THE 1997 COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND THEIR FAMILIES PROGRAM

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The National Resource Network for Child and Family Mental Health Services at the Washington Business Group on Health

Contributing Sites:

California V (Riverside, San Mateo,
    Solano, Santa Cruz and
    Ventura Counties)
Napa and Sonoma Counties, California
Santa Barbara, California
Kapolei, Hawaii
Broadview, Illinois
Parsons, Kansas
Wichita, Kansas
Bangor, Maine
Baltimore, Maryland
Dona Ana County, New Mexico
Tohatchi, New Mexico

North Carolina
Bismarck, North Dakota
Bronx, New York
Southeastern and Stark
    Counties, Ohio
Eugene, Oregon
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Charleston, South Carolina
Burlington, Vermont
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Table of Contents

Table of Contents, Continued

Foreword

It is with great pleasure that we present the first collection of monographs from the *Promising Practices Initiative* of the Comprehensive Community Mental Health Services for Children and Their Families Program. The Comprehensive Community Mental Health Services for Children and Their Families Program is a multi-million dollar grant program that currently supports 41 comprehensive systems of care throughout America, helping to meet the needs of many of the 3.5 to 4 million children with a serious emotional disturbance living in this country. Each one of the seven monographs explores a successful practice in providing effective, coordinated care to children with a serious emotional disturbance and their families.

The 1998 Series marks a turning point in this five-year-old federal effort, which is administered by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. The first generation of five-year grants is about to come to an end, and with that "graduation" comes a responsibility to add to the national knowledge base on how best to support and service the mental health needs of children with serious emotional disturbance. Until the very recent past, these young people have been systematically denied the opportunity to share in the home, community and educational life that their peers often take for granted. Instead, these children have lived lives fraught with separation from family and community, being placed in residential treatment centers or in-patient psychiatric centers, hundreds and even thousands of miles away from their home. For many of these young people, a lack of understanding of their psychopathology, underdeveloped or non-existing community resources, and a sense of frustration of what to do have led to their eventual placement away from home.

The *Promising Practices Initiative* is one small step to ensure that all Americans can have the latest available information about how best to help serve and support these children at home and in their community. Children with serious emotional disturbance utilize many publicly funded systems, including child welfare, juvenile justice, special education, and mental health, and they and their families often face many obstacles to gaining the care they need due to the difficulties and gaps in navigating multiple service systems. Systems of care provide a promising solution for these children and their families by coordinating or integrating the services and supports they need across all of these public service systems.

The information contained within these monographs by and large has been garnered within the original 31 grants of the Comprehensive Community Mental Health Services for Children and Their Families Program. The research was conducted in a manner that mirrored the guiding principles of the systems of care involved so that it was family-driven, community-based, culturally relevant, and inclusive. Methods for information collection included: site visits and focus groups; accessing data gathered by the national program evaluation of all grantees; and numerous interviews of professionals and parents. Family members were included in the research and evaluation processes for all of the monographs. Two of the papers directly address family involvement, and all of the papers dedicate a section to the family's impact on the topic at hand. The research was drawn from the community-based systems of care and much of the research comes from systems of care with *culturally diverse populations.*

The 1998 *Promising Practices* series includes the following volumes:

Volume I - *New Roles for Families in Systems of Care* explores ways in which family members are becoming equal members with service providers and administrators, focusing specifically on two emerging roles: family members as "system of care facilitators" and "family as faculty."

Volume II - *Promising Practices in Family-Provider Collaboration* examines the fundamental challenges and key aspects of success in building collaboration between families and service providers.

Volume III - *The Role of Education in a System of Care: Effectively Serving Children with Emotional or Behavioral Disorders* explores sites that are overcoming obstacles to educating children with a serious emotional disturbance and establishing successful school-based systems of care.

Volume IV - *Promising Practices in Wraparound* identifies the essential elements of wraparound, provides a meta-analysis of the research previously done on the topic, and examines how three sites are turning wraparound into promising practices in their system of care.

Volume V- *Promising Practices: Training Strategies for Serving Children with Serious Emotional Disturbance and Their Families in a System of Care* examines theories of adult learning, core values, and four key areas (cultural competence, family-professional relationships, systems thinking, and inter-professional education and training), and looks at promising practices that are combining these concepts into a successful sustainable training program.

Volume VI- *Promising Practices: Building Collaboration in Systems of Care* explores the importance of collaboration in a system of care focusing on three specific issues: the foundations of collaboration, strategies for implementing the collaborative process, and the results of collaboration

Volume VII - In *A Compilation of Lessons Learned from the 22 Grantees of the 1997 Comprehensive Community Mental Health Services for Children and Their Families Program*, the grantees themselves share their experiences in five main areas: family involvement/empowerment, cultural competency, systems of care, evaluation, and managed care.

These seven documents are just the beginning of this process. As you read through each paper, you may be left with a sense that some topics you would like to read about are not to be found in this series. We would expect that to happen simply because so many issues need to be addressed. We fully expect this series of documents to become part of the culture of this critical program. If a specific topic isn't here today, look for it tomorrow. In fact, let us know your thoughts on what would be most helpful to you as you go about ensuring that all children have a chance to have their mental health needs met within their home and community.

So, the 1998 *Promising Practices* series is now yours to read, share, discuss, debate, analyze, and utilize. Our hope is that the information contained throughout this Series stretches your thinking and results in your being better able to realize our collective dream that all children, no matter how difficult their disability, can be served in a quality manner within the context of their home and community. COMMUNITIES CAN!

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Acknowledgments

This *Promising Practices* series is the culmination of the efforts of many individuals and organizations that committed endless hours participating in the many interviews, meetings, phone calls, and drafting of the documents that are represented here. Special appreciation goes to all of the people involved in the grants of the Comprehensive Community Mental Health Services for Children and Their Families Program for going beyond the call of duty to make this effort successful. This activity was not in the grant announcement when they applied! Also a big thank you to all of the writing teams that have had to meet deadline after deadline in order to put this together in a timely fashion. The staff of the Child, Adolescent and Family Branch deserve a big thank you for their support of the grantees in keeping this effort moving forward under the crunch of so many other activities that seems to make days blend into months. Thanks to David Osher and his staff at the Center for Effective Collaboration and Practice for overseeing the production of this first *Promising Practices* series, specifically: Lalaine Tate for word processing and layout design; Lenore Webb for carefully editing all the manuscripts during the final production phases; Cecily Darden for assisting in editing and proofreading; and Allison Gruner for coordinating the production. Finally, a special thank you to Dorothy Webman, who had the dubious pleasure of trying to coordinate this huge effort from the onset. While at times it may have felt like trying to move jelly up a hill, Dorothy was able to put a smile on a difficult challenge and rise to the occasion. Many people have commented that her commitment to the task helped them keep moving forward to a successful completion.

The National Resource Network for Child and Family Mental Health Services wishes to gratefully acknowledege the generous contributions of time and work from the 22 Grantees of the 1997 Comprehensive Community Mental Health Services for Children and Their Families Program in the development of these papers. Their willingness to share their experiences of lessons learned and successes is, in a very true sense, the best technical assistance available to anyone embarking upon developing systems of care for children with mental, emotional and behavioral disorders and their families. In addition, sincere appreciation and thanks is extended to Ms. Ann Makowski, Washington Business Group on Health, for her indefatigable proofreading of the papers.

Executive Summary

Designing systems of care to serve children and adolescents with serious mental, emotional, and behavioral disorders and their families within the context of the environment in which many of our child-serving systems operate can be an extremely daunting task. Eleanor Roosevelt described what could be the "root" of the problem this way:

> Service programs develop in response to the conceptualization of problems and needs, available technologies, and results considered desirable or essential. Inevitably, in the course of the history of our "human services" repertoire, programs have developed reflecting different value judgements, institutional, and governmental histories, and assignments or assumptions of responsibility (Kahn and Kamerman, 1992).

Consequently, we should not be surprised that many of the programs developed for children and their families do not work. Far too many of them are categorical, not culturally relevant or competent, and more important, they fail to take into consideration the specific or individualized needs of children and families. In some instances, the program design is more heavily directed toward meeting the needs of the system or organization rather than the child and his/her family.

The 22 Grantees of the 1997 Comprehensive Community Mental Health Services for Children and their Families Program have accumulated rich and colorful experiences in the design, development and implementation of community-based, family-focused and culturally competent systems of services for children and adolescents with mental, emotional and behavioral disorders and their families. This Federal grant program is a national effort to help communities establish systems of care that ensure the availability of appropriate services that include these principles for children and families. Funded and administered by the Child, Adolescent and Family Branch of the Federal Center for Mental Health Services, it supports the development of activities that will ultimately become "best practices" in the field of children's mental health. Thus far, more than 31 communities have been selected to participate in this work.

A Compilation of Lessons Learned from the 22 Grantees of the 1997 Comprehensive Community Mental Health Services for Children and Their Families Program is part of an ongoing effort to document lessons learned from the implementation of the Federal grant program. It is produced by the National Resource Network for Child and Family Mental Health Services at the Washington Business Group on Health. Also funded by the Comprehensive Community Mental Health Services for Children and their Families Program, the National Resource Network was established in 1994 to provide field-based technical assistance to these sites. The Program assists the service sites in strategic planning for implementing their vision of a comprehensive system of care based on shared values and principles that include services that are family-driven, individualized, focused on strengths, culturally competent, coordinated across child-serving systems, and most importantly effective for the community and the children and their families.

The sites were asked to document their "Lessons Learned" in implementing the federal grant programs. An author from each of the 22 original services sites writes each story from their own experience "on the front line and in the trenches." They are shared with the reader in the hope that others who are working toward a community-based, family-focused, culturally competent system of care can benefit from their efforts, and move toward success more quickly. The collection covers five important areas: 1) family involvement/empowerment, 2) cultural competence, 3) systems of care, 4) evaluation, and 5) managed care.

FAMILY INVOLVEMENT/FAMILY EMPOWERMENT

In the area of *Family Involvement/Family Empowerment*, several of the stories discuss the importance of involving families from the very beginning of system design and development. The Wichita, Kansas site very clearly describes their learning curve in support of their family advocacy program. It points out the expectations of key stakeholders in the site who were involved in supporting a fledgling effort. Along the same lines, the South Philadelphia Family Partnership speaks of multi-level family involvement, at both the individual case level and the system level, ensuring that family involvement is not "tokenism" but truly includes family participation and power.

The Hawaii Ohana Project notes the importance of family involvement and how it is supported, and also describes how family members play key roles as trainers, data collectors and direct service providers. The four counties in rural Maine also plowed new ground in their state by adding parent advocates to the service provider team. These individuals work side-by-side with case managers and receive the same training as other professionals. The Maine project offers the reader specific pointers on how to maintain this type of relationship and build trust among new partners.

Project ACCESS in Alexandria, Virginia emphasizes the importance of early, active involvement by a family organization. This early involvement assisted staff in addressing the many administrative issues that may prohibit full family involvement such as childcare, transportation, meeting schedules, etc. The Parent in Residence program at East Carolina University is an integral part of the North Carolina Pitt and Edgecombe-Nash Public Academic Liaison (*PEN-PAL*) project which ensures integration of a family perspective in all training and technical assistance activities. Finally, the Napa and Sonoma County sites present the impact of hiring family members as staff persons on systems change. They explain that hiring parents is not enough. Such efforts should be coupled with a commitment to change practice. From their experience, they note that total systems overhaul can occur when professional staff and family members work side by side.

Specific Family Involvement Lessons Learned:

■   Involve families from the very beginning of system design and development

- Multi-level family involvement, at both the individual case level and the system level, ensures that family involvement is not "tokenism"

- Family members can play key roles as trainers, data collectors and direct service providers

- Include parent advocates on the service provider team

- Trust is necessary to build and maintain positive relationships among new partners

- Integration of a family perspective in all training and technical assistance activities s important

- Hiring parents is not enough, it needs to be coupled with a commitment to change practice

CULTURAL COMPETENCE

The Charleston, South Carolina project has written very useful lessons learned on Cultural Competence called "The Never Ending Journey Towards Cultural Competence in the Charleston Village: If It Doesn't Feel Like Help, It Isn't." The Charleston project reminds us in clear, useful terms that cultural competence is not just a training session, but a roadmap for how our work should be conducted as we build and implement responsive systems of care.

A unique perspective regarding cultural competence issues encountered by a Native American site as they build a system of care is presented in the K'e Project story. This brief interview with the executive director highlights the impact of cultural differences. An example highlighted in the story is the requirement that all documents be completed in two different languages. The project reminds readers from non-Western cultures to be aware of federal rules, especially Medicaid, when beginning a project. Specific rules such as timelines for completion of assessments and other interventions are very difficult in a culture that has a different language, in rural communities and where other cultural differences exists that make adherence to western culture rules difficult.

Specific Cultural Competence Lessons Learned:

- Cultural competence is not just a training session, but a roadmap for how our work should be conducted as we build and implement systems of care.

- Be aware of federal rules, especially Medicaid, when beginning a project in a culture that has a different language and different cultural beliefs from Western culture.

SYSTEMS OF CARE

Several projects wrote about various aspects of building systems of care in their community, as well as the issues that must be addressed in order to be successful. The Southern Consortium, comprised of

three rural southeastern Ohio communities, outlines the positive outcomes they experienced when they stationed a mental health worker in each of the juvenile court offices to serve as a liaison to those courts. Stark County, Ohio offers an example of how they built upon the unique county-based infrastructure in Ohio to build their system of care. Their experience suggests that in order to be successful and sustainable, the system of care must be folded into the community's existing governance and infrastructure. The Wraparound Milwaukee project illustrates the importance of using positive outcomes for the children and families served to achieve buy-in from key decision-makers. These efforts can be used to develop sustainable approaches to working with local systems in providing a community-based, family-focused system of care.

The project in Bronx, New York provides lessons learned in working with the local schools and families within the community-based system of care. The site used a Mobile Community Support Service to realize their success in the Mott Haven community. The North Dakota Partnership project also illustrates the importance of building inter-agency relationships in the development of a community-based system of care. Comprehensive training for staff and families at all levels is noted as a key feature in their success. The Santa Barbara, California project lists several barriers they encountered in building a community-based, family-focused system of care; corrective strategies for each barrier are detailed such as, build on the strength of the child and family, use family to family support, and communication is enhanced by regular meetings of all child serving agencies in the community. In the same vein, the Lane County, Oregon project identified barriers to achieving a sustainable system of care and gives the reader examples of actions that worked best for them.

The Access Vermont project, located in one of the most rural states in the country, offers the reader a model for building systems of care in rural communities. The project highlights their success with a wide array of providers including domestic violence programs, child-care centers, and youth service bureaus, as they built their system of care. The Baltimore, Maryland project also illustrates the importance of involving the non-traditional mental health provider in their system of services. They developed their partnership with the Baltimore Police Department Eastern District to form the East Baltimore Community Oriented Policing Services Program, an exciting initiative which focuses on children who experience urban violence and their families.

The State of Rhode Island's contribution involves a Service Coordination Training curriculum. This four-day, 12-module training program has become one of the critical mechanisms through which the basic values that underlie the system of care movement in Rhode Island are reflected and reinforced.

Specific System of Care Lessons Learned:

- Systems of care must be folded into the community's existing governance and infrastructure

- A sustainable approach to working with local systems is to contract with them for services to the target population as an alternative to costly residential treatment

■ Stationing a mental health worker in each of the juvenile court offices to serve as a liaison is an example of how partnerships can be developed

■ A Mobile Community Support Service that brings the needed services directly to the schools builds successful partnerships

■ Comprehensive training for staff and families at all levels is necessary

■ Working with a wide array of providers including domestic violence programs, child-care centers, and youth service bureaus, builds a true community response to the system of care

■ Involving the non-traditional mental health providers, such as the police can build strong community based partnerships for the system of care

EVALUATION

The Community Wraparound Initiative in Broadview, Illinois lesson learned focused on evaluation. They share suggestions on how to make evaluation an integral part of the system of care such as including the identification stakeholders and how to use evaluation data to improve the system of care. KanFocus provides an even more comprehensive look at the importance of evaluation and offers additional recommendations for effectively using data as an effective navigational tool for systems change.

Specific Evaluation Lessons Learned:

■ Evaluation must be an integral part of the system of care

■ Data from integrated systems of care evaluation can be an effective navigational tool for systems change

MANAGED CARE

Five counties in California formed a single uniform project known as the "California V". This project describes how they took the California System of Care and expanded it to the broader population covered by the Medicaid carve out for behavioral health care. They illustrate how the system of care approach to service delivery subsumes and surpasses the managed care goals by adding an emphasis on individualized services, family involvement, cultural competence, and consumer cost outcomes. By incorporating the system of care into the managed care goals, the overall system brought greater effectiveness and "humanness" to the service delivery system.

The Dona Ana County Child and Adolescent Collaborative, located in New Mexico, shares its experience concerning the impact of managed care on systems of care development. The site poignantly

points out the difficulties that have been experienced in trying to merge the values of systems of care with the need to contain costs in a managed care environment. They further note how these experiences have taught the participants to be more creative.

Specific Managed Care Lessons Learned:

■ Incorporating system of care values into the managed care goals, can bring greater effectiveness and "humanness" to the overall service delivery system

■ Merging of system of care values with the need to contain costs in a managed care environment can be a daunting task

A Compilation of Lessons Learned from the 22 Grantees of the 1997 Comprehensive Community Mental Health Services for Children and Their Families Program is not an exhaustive review of programs that work, but rather it is intended to be a resource for communities who are involved in developing and redefining systems of care to meet the needs of their children and families. The sites have all been successful in their individual communities, building the partnerships necessary to assure successful systems of care. Findings from national and local evaluations of these programs suggest positive outcomes for children and youth with serious emotional disturbance and their families when children are cared for in their homes and communities.

Highlights from these evaluations are:

■ Reduced residential and inpatient costs
■ Reduced mothers' unemployment
■ Reduced psychiatric hospitalizations
■ Reduced residential lengths of stay
■ Reduced out-of-community placements

Children and adolescents who have received care through the projects from 1993 to the present have:

■ Fewer school absences
■ Fewer failing grades
■ Fewer crimes committed

These data can be found in the Comprehensive Community Mental Health Services for Children and Their Families Program's Ten Key Findings, May. For more information, please contact the Center for Mental Health Services at (301) 443-1333.

REFERENCES

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Implementing Systems of Care in a Managed Care Environment

California V

Marty Giffin, Principal Investigator

In 1993, the California State Department of Health Services released its plan for "carving out" all Medi-Cal funds for mental health services. Obviously this plan would impact the five counties (Riverside, Santa Cruz, San Mateo, Solano, Ventura) funded by the Center for Mental Health Services to develop systems of care for children who have serious emotional disturbances. Phase I of the managed care plan began in 1995, when counties assumed the responsibility and risk for all medically necessary mental health inpatient services provided to eligible Medi-Cal beneficiaries. Phase II requires the consolidation of all outpatient specialty mental health services and is being phased in during 1997 and 1998. When full consolidation is complete, county mental health programs will have the risk and responsibility for all medically necessary mental health services to the Medi-Cal population. For services to children and youth, this means the expansion of the originally defined *California System of Care* target to a broader population with less serious emotional disturbance.

Managed care plans include four primary goals: Access, Quality, Cost and Satisfaction. In addition, the overarching function of managed care is a financial mechanism designed to control and maintain a precise amount of service care, no more or less than necessary. Cost containment is a goal shared by both managed care and the *California System of Care* model. However, an effectively implemented system of care subsumes and surpasses this and other managed care goals. Finally, with an emphasis on individualized services, family involvement, cultural competence, and consumer cost outcomes, the *California System of Care* is driven by a higher set of principles to bring effectiveness and greater "humanness" to service delivery systems. This work highlights how, in the area of services to children and families, the *California System of Care* model can successfully address each of the managed care goals.

ACCESS

- Once the target population for managed care is defined, a system that will improve access can be developed.

- Agency and family professional partnerships can be used to identify a broader stakeholder community who can more effectively design and implement the managed care plan.

- Agency and family partnerships can also assist in the development of a broader service array for the target population.

■ Agency partnerships can blend and leverage funds to maximize resources needed to expand services to children and families.

■ The concept of reinvestment of savings, implemented cooperatively across agencies, can facilitate the creation of prevention and early intervention programs that will increase access and help reduce risk.

QUALITY

■ With a priority on accountability regarding outcomes, the *California System of Care* model can be used to manage care appropriately. One of the measures of quality care is whether or not it produces the desired outcomes and consumer satisfaction.

■ The *California System of Care* model offers an "unlimited" benefit package. This broad array of services, along with an emphasis on individualized services, tailored to the child and family's needs, will accomplish and increase the system's ability to provide quality care.

■ The *California System of Care* model offers multiple opportunities for families, partner agencies, and the community to define and assess "quality." The incorporation of multiple perspectives across domains will lead to more emphasis on providing families with what they need and want.

COST

■ Cost effective services are continually addressed through the implementation of measurable goals and accountability regarding outcomes.

■ The *California System of Care* model not only addresses mental health costs, but contains costs across agencies, thus offering opportunities for cost savings which can then be reinvested in additional services and/or expansion of the target population.

■ Blending and leveraging funds through agency partnerships facilitates greater cost efficiencies.

■ When agencies work as partners, they can better manage their collective financial risks.

SATISFACTION

■ Family/professional partnerships and cultural competence offer opportunities to influence the values of the service delivery system and its providers, resulting in greater consumer satisfaction.

■ The *California System of Care* model uses standardized instruments for measuring consumer satisfaction.

■ Family/professional partnerships allow broader input into the planning and development of managed care systems. Stakeholders have meaningful involvement, which can result in greater satisfaction.

The implementation of managed care also presents some challenges and lessons learned that should be addressed.

- The streamlining and centralizing of some functions under managed care may not always be fully compatible with the *California System of Care*. For example, centralized access may add a "hurdle" for interagency partners and may not apply to jointly operated interagency programs. In these instances, the system of care should "drive" managed care decisions, rather than the other way around.

- Increased visibility and the expansion of the target population may increase demand for services. Providers need to be ready to respond to this demand in a timely manner, as well as manage this demand within the available resources.

- Methods must be developed to define and monitor the quality of services to the expanded target population. This may require different measures than those used to assess services for children with more serious mental, emotional and behavioral disorders. Children and families requiring shorter-term interventions and/or where risk of out-of-home placement is not an issue may require different types of evaluation instruments.

- More formal grievance procedures are required under managed care. The formal nature of this process requires creativity approaching this from a partnership point of view.

- Containment of acute care costs is critical. As the system of care successfully returns more children from out-of-home placement, it may have an impact on hospitalizations. Acute care may be used to avoid longer-term out-of-home placements or as after care upon return from placement. While an increase in acute care may be appropriate in these instances, it may create issues for the larger behavioral healthcare system.

- To be competitive with the private managed care sector, mental health systems as a whole must become more sophisticated in their data collection and retrieval capabilities. Ways to get better cost data on individual children and their families served by the system of care should be fully explored.

- Managed care, in and of itself, is neither bad nor good; it is merely a tool for organizing and delivering services. The *California System of Care* offers the best model for organizing and delivering services to children and their families, and is inherently compatible with managed care principles.

Lessons Learned from Napa-Sonoma County Sites

Napa and Sonoma Counties, California

This project involves two contiguous counties in the northernmost San Francisco Bay Area. While the grant was written and received jointly, the two counties operate independently. They do however share and pool certain resources including consultants, training opportunities and a short-term crisis residential program. Additionally, both sites share a sincere commitment to using the Center for Mental Health Services grant to build firm partnerships with parents as a centerpiece of their system of care efforts. This commitment was demonstrated in the fact that some of the first staff hired at the site were parents. While each site shared a common philosophy and were able to share some resources, each site had some major differences. These differences included actual project design and community and system context in which the projects were implemented.

Napa County

This project began with a centralized change model by configuring a cross-system team known as the System of Care Unit. Housed in Mental Health, which is part of an integrated Health and Human Services Department that includes Public Health, Child Welfare and Mental Health, this unit was configured by recruiting staff from other child-serving departments as well as Mental Health. Representatives included Mental Health and Juvenile Probation, with several of the staff who volunteered for this unit including people with a Child Welfare and Family Preservation background. This specialized unit became the focus of activities during the initial grant cycle. In an effort to integrate the system of care approach, Children's Mental Health Outpatient staff were integrated with the System of Care Unit during the third year of the grant. This resulted in a reformulation of all children's mental health services within the County. Current efforts are focused on strengthening the collaborative focus of activities as well as developing a sound refinancing package. Parents have been an integral part of service delivery and policy in this site through a subcontract with a parent-run educational advocacy group. Expansion of this capacity into other systems and maintenance of efforts to sustain the current successes with parent involvement are a key focus of activities as the federal grant nears completion. A parent advisory group was configured early on during the life of the grant, which guided project decision making.

Sonoma County

This project adopted a more disseminated model of change by assigning project staff throughout service sites within the county. Case Management Specialists were housed throughout

the mental health system while a specialized probation position was housed in Juvenile Court and a Treatment Foster Care Specialist was placed within Child Welfare. All county mental health staff were originally conceptualized as part of the system of care with the grant funding some specialized capacities. This meant that all children receiving county mental health services were also seen as within the scope of the grant as well. Parents were hired as county employees and placed in clinic sites alongside clinicians. Early collaborative efforts included a System of Care Task Force, which was inter-system in nature, and a Family Partnership Committee composed of professionals and parents together. Because of the nature of the project, roles between project staff and ongoing county staff blurred at an unusually fast rate. As a result, in the fourth year of the grant, County Mental Health reorganized their entire structure to more closely align with system of care principles. This reorganization consisted of configuring regionally based generalist teams rather than organizing around service specialties such as case management and outpatient services. Additionally, midway through the grant the county began to work on strengthening its collaboratively based governance structure consisting of top level executives of each of the county departments as well as parent representatives. That group is not only providing oversight for the grant but building a forum for overall children's policy development, collective leadership, and refinancing of children's services.

The heart of efforts associated with the Center for Mental Health Services grant in both counties involves partnerships with parents and professionals. That essential core value has driven project activities from the beginning. When the project began it was unclear what impact opening the organizational doors to parents would have. Throughout the project, unanticipated consequences and benefits were realized by having parents paired with clinicians during the first contacts families had with the system of care. Nevertheless, parent partnerships became a type of mooring for the change activities which occurred in these two counties.

LESSONS LEARNED ABOUT THE CHANGE PROCESS IN NAPA AND SONOMA COUNTIES

First Lesson Learned: System of Care work is intensely personal for staff and parents.

What We Could Have Done Better: Created more opportunities for personal dialogue.

You cannot duck the people problem. This grant meant more than simply adding new services to the community and system. The grant provided the opportunity to begin the conversation with all staff and families about the underlying principles and beliefs which were guiding current system operations. What was not anticipated was how painful this discussion about personal values

and beliefs could be for staff as well as parents. In focusing on underlying beliefs rather than new techniques or services, parents and professionals had to explore those underlying beliefs together. Sometimes that was threatening for both parties. This rich conversation, however, also provided the opportunity for the system to be creatively redesigned based on the personal experiences of those most involved. Each person involved in the metaphor of help for a single child and family had to consider his or her personal role in defining that experience.

Systems are not often good at nurturing the personal nature of the change process. Even as many of the structures surrounding this personal experience seemed to calcify, staff and parents changed together. In the midst of service delivery, the personal nature of the change runs the risk of being forgotten. Both sites used off-site retreats which included parents and staff as well as smaller venues such as staff meetings to have the conversation. There were not enough of these opportunities provided due to the need to keep the agency doors open for business. A number of strategies which could have been helpful included finding fill-in staff and facilitating conversations more often within existing activities.

Second Lesson Learned: Close quarters with parents and program staff create a real opportunity.

What We Could Have Done Better: Understood that this would be stressful for both parties and helped them anticipate that stress.

Both sites elected to aggressively integrate parents into service sites. Napa county chose to subcontract the parent positions through an educational advocacy group, Sonoma hired parents as staff. Despite the fact that parents associated with the Napa project were subcontracted their organizational home was shared with existing clinicians and service providers. Likewise with the parents associated with the Sonoma Project. The fact that they worked alongside each other on a daily basis provided a rich opportunity for discussions about the stated paradigm shift. This allowed for exploration of roles and assumptions about care. It also provided an opportunity to model alliances for children and families within the system of care. On the other hand, management was forced to respond to the struggles associated with these close quarters. Clinical staff were initially challenged by the presence of parents in service sites who were directly involved in their work. Issues of access to files, confidentiality with each other and basic roles were raised frequently during the initial presence of parents. Many of the simplest protocols looked as if they would become the most challenging barriers. It would have been helpful for both staff and parents to have an opportunity to hear what the challenges would be prior to location. Additionally, some protocols could have been developed prior to the presence of parents which would have helped staff and parents to understand the rules of the game.

Third Lesson Learned: Hiring parents is not enough; it needs to be coupled with a commitment to change practice.

What We Could Have Done Better: Built a practice model, tested it and then moved it out to all staff for implementation and adaptation.

The presence of parents is not enough to create a system of care. Efforts to change practice must be coupled with the presence of those parents. As staff learned a new practice model with a corresponding set of approaches and technologies, parents were integrated into that new practice model. Coupling the paradigm shift with the presence of parents eventually allowed for an openly negotiated set of roles for both staff and parents. If practice had not been expected to change, the risk was always present that parents would take on the roles of clinicians operating in a deficit-driven system. Parents hired often found themselves as cheerleaders for new practice methods as well as functioning as system healers. In their role as system healers they found themselves often supporting staff who were mourning their role in the old system or experiencing real fear that they were irrelevant in the emerging system. The introduction of new practice models afforded parents and staff the opportunities to try on new roles together. In both counties parents function as Wraparound Facilitators in some situations. In other situations, they are Parent Partners while Clinicians function as Wraparound Facilitators. The important point is that parents and staff are making these decisions about roles together based on the needs of the family seeking help.

One challenge with the change in practice and introduction of the parents was that these things occurred almost simultaneously. This was difficult in that the model was changing as staff roles were changing. As a result, the change process often overwhelmed people. It would have been helpful to clearly define the practice model in terms of structures and processes before introducing it to staff. Since the definitions of best practice were still a work in progress at the time of introduction to the system, it would have been helpful for both staff and parent partners to have more anchors or handholds. The practice model could have been more developed and defined at the time of introduction to the larger system.

Fourth Lesson Learned: You will get a total system overhaul . . . whether you expect it or not.

What We Could Have Done Better: Expected it sooner.

Both counties had existing structures, process and resources available when they applied for their grant. Interestingly enough, both counties have gone through major overhauls since the grant was received. In Napa County, the Outpatient Mental Health Unit was merged with the System of

Care Unit. This was a type of reverse inclusion for the change process. Rather than moving the System of Care Innovators out into the existing system, the existing system was moved into their reality. Sonoma County had a major restructuring which collapsed traditional units into regionally based, generalist teams assuming responsibility for all children in need of services within a certain geographical area. Some of these changes had to do with the presence of the grant and the growing realization that the organizational context did not always fit the goals espoused in the grant. A large part of it had to do with the state context as managed care principles were implemented across the state. Everyone's role within Mental Health has changed. The grant provided a forum and context for that change to occur.

SUMMARY OF FOUR LESSONS LEARNED

Many of the lessons learned in this county were serendipitous which is the nature of the change process. What we learned from the use of the paradigm shift framework is that all stakeholders needed to be able to process who they were, not just what they did. The presence of parents yielded more support for the change process than we ever thought possible. That was partially because of the close quarters which put staff and parents in the same place working together. That was also because the paradigm shift became more than mere words. It became operationalized in a practice model which is still under construction. When that practice model was provided to staff, the words attached to the definition of the paradigm shift began to have real meaning for all stakeholders in the system. Over time, the lack of cohesiveness between the principles and the organizational structure resulted in a need for a total system overhaul. All four of these lessons learned are interrelated although each point has the ability to stand alone.

Building Systems of Care

Santa Barbara County Multiagency Integrated System of Care (MISC)
Santa Barbara, California
Todd Sosna, Project Director

The Santa Barbara County Multiagency Integrated System of Care, in partnership with families, schools, Alcohol, Drug and Mental Health Services, Child Protective Services, Public Health, Probation and private child and family serving agencies, is a mutual benefit partnership which has developed a precision of fit delivery system serving youth who exhibit serious emotional or behavioral disorders and their families. Primary characteristics of the System of Care include a single, family-focused, comprehensive assessment and a single, family-focused, cross-agency service plan. The project is defined by its emphasis on mutual benefit collaboration and precision-of-fit delivery. The Multiagency Integrated System of Care has been transitioning from a paternalistic paradigm in which staff "do for others" in an effort to meet the needs of youth, to a "supportive autonomy" characterized by services that build on family strengths and enable parents and families to successfully care for their children.

LESSONS LEARNED

Events occur in any building process that can be barriers to achieving the expected goals and objectives of the project. As we encountered barriers to achieving our goals, we have used these barriers to cement more firmly the foundation of our System of Care through family involvement, co-location, collaboration and performance outcomes. The following are barriers that the Multiagency Integrated System of Care has encountered and the corrective strategy taken to overcome those barriers to achieve the Multiagency Integrated System of Care goals and objectives in building a system of care for children and families. These corrective strategies are our lessons learned.

Agency staff tend to make decisions in response to crises in families. When agency staff engage in this kind of decision making across the child and family service system, family responsibility is undermined rather than encouraged. Additionally, more services are generally required and they result in relatively less success.

Corrective strategy. The Multiagency Integrated System of Care has sponsored and provided cross-agency training to support a model of service planning, delivery and evaluation that builds on child/family strengths. By developing strategies which create respectful, joint service planning and cross agency consultation, duplication and fragmentation of services have been replaced and a responsive local program evaluation has allowed the county to develop precision of fit. Services are identified which meet the needs identified by families and staff; they are provided

through cross-agency collaboration and coordination and are managed for outcomes through performance expectations, resulting in improved client satisfaction and better client outcomes at less cost.

Agency staff hold the assumption that there are insufficient resources. When staff are working in programs that they feel are under-funded to meet the need of their customer children and families, they become demoralized. As a result, they tend to expect less success from their families and from themselves and their agencies.

Corrective Strategy. By building family-to-family support into the delivery system, families begin to feel less stigmatized and less isolated. Family to family connections greatly enhance the support and services available in the system of care which encourages both families and staff. As individualized service plans are developed that is goal directed and provide services, which enhance autonomy, families and staff find additional, non-traditional resources in themselves and the community. A greater sense of possibility and hope for change is created.

Confidentiality and appropriate access to and use of information is a concern. The traditional system safeguards against misuse of information by restricting access. The Multiagency Integrated System of Care is premised on the belief that sharing information is necessary for a system to be seamless; however, misuse of information erodes partnership.

Corrective strategy. Help agencies learn from specific examples about where sharing information has worked well and where it has not. Sharing successes and challenges in an atmosphere of trust across agencies and being honest with one another has provided examples to build on and from which to learn. Cross-system training on the use of information has proved invaluable. This is done consistently, from a developed curriculum and regularly for newly hired staff across agencies. Additionally, revision of forms and charting using relevant and helpful language and reports has been critical to building success. Agreements across agencies about what is shared and developing a common language across the child and family service system have built trust and team work rather than suspicion and agency self-protection. Integration of families into public agencies has also sensitized staff to the need for attitude and procedural changes to support teamwork.

Providers do not always work as partners with families. Attempting to effect improvement without family support results in less effective outcomes and higher costs.

Corrective strategy. We provided small group, intensive training with family members as co-trainers. This training initiated a change in the perceptions and beliefs of staff as expectations for their work began to change. Outcome evaluation showing improved outcomes when family "mentors" are involved and when consumers are satisfied has given staff both information and an understanding of how outcomes of work provided in a family-friendly, outcome-based environment are more satisfying to provide and receive. The importance of immediate feedback to staff through quick data turn around in a "provider-friendly" format has been crucial to the success of the Multiagency Integrated System of Care. Co-location of family members with cross agency staff has also been an invaluable strategy in building a new culture.

There is a lack of coordination between regional cross-agency supervisors and/or managers. This results in inconsistency of direction, less ownership by cross agency staff (who often lack the big picture) and a failure to maximize cross-agency knowledge.

Corrective strategy. Conduct regular regional and countywide cross-agency supervisor/manager meetings. These meetings have provided the opportunity for supervisors/managers to learn from one another and create a culture of collaboration and cooperation. They also allowed the supervisors/managers to develop cross agency policies and procedures that supported collaborative work rather than inhibiting it. The value of collaboration by these supervisors/managers then encouraged the prioritization of the Multiagency Integrated System of Care by the agency administrators. Supporting the supervisors/managers served to build on and spread the culture of collaboration and shared values.

Staff does not work as a team with joint financial responsibility for outcomes. This resulted in an inefficient use of resources and unclear priorities.

Corrective strategy. Provide monthly management reports showing service utilization and expenditures. This information provided the impetus for behavior change. Regional control of budget also provided incentives and accountability for cross agency goals and outcomes. Also important was empowering care coordinators to authorize services and adjust those services as needed. Training and co-location of staff provided motivation, but information and control provide powerful tools for changing staff behavior.

In summary, a clear understanding of the barriers we encountered in implementing our vision helped us target our strategies for maximum success. Now we are working to institutionalize the system reform to ensure proactive service delivery to children and their families that supports an autonomy-centered system of care.

Family Involvement Successes

Hawaii Ohana Project
Kate Pahinui, Project Director

The *Hawaii Ohana Project* encompasses two mental health catchment areas on the relatively dry western portion of Hawaii's Island of Oahu. Persons of Filipino descent predominate in the rapidly growing suburbanized Leeward Oahu community, which is centered at Waipahu and is about 18 miles from downtown Honolulu. A single main road connects the Leeward Ohana community with the rural Waianae Coast, Oahu's heart of Hawaiian culture. Native Hawaiians make up about 55 percent of the Waianae coast population (compared to about 20 percent statewide), largely because of the availability of homestead land reserved for them.

When compared to Hawaii as a whole, the Waianae Coast and, to a lesser extent Leeward Oahu, has a disproportionate number of families living in poverty, school drop-outs, teenage pregnancies, homeless school-aged children, juvenile offenders, and substance-abusing youth. The mental health needs in this area are great. Nevertheless, the area also has noteworthy strengths on which to build community-based systems of care, including a high level of community organization, a tradition of neighbor helping neighbor, and traditional cultural values that stress the importance of strong families and self-reliance.

THE IMPORTANCE OF FAMILY INVOLVEMENT

The initial design of the *Hawaii Ohana Project* included a strong focus on family involvement based on the belief that an initiative will work best if the people who will be most affected have a strong voice in the design and implementation. Because the project design was built upon the Child Adolescent Service System Program values that services must be child- and family-focused, it was considered especially important that family input be valued and formally incorporated at all levels of the system of care. It was assumed that strong family input would help make policies, procedures, and practices more responsive to family strengths and needs and, as a result, better outcomes would be achieved for the youngsters and families served.

How Family Involvement Is Supported

Family involvement began with the development of the initial application for funding of the *Hawaii Ohana Project* from the Center for Mental Health Services. Two family representatives, a university-based family consultant, and an advocate were involved in the design and development of the application. The design included family representation at all project levels, including policy (Governing Council membership), program (work group and personnel hiring committee

participation), and practice (as members of individualized service planning teams for their own children). In addition, *Hawaii Families As Allies* (the state chapter of the Federation of Families for Children's Mental Health) was named in the grant application as a subcontractor providing family support services. The organization was chosen as a partner because of its history of experience in empowering families to effectively participate in the service system.

The *Hawaii Families As Allies* subcontract includes a variety of family support and advocacy activities. Persons hired to conduct these activities are all para-professional level parents of youngsters with serious emotional disturbances. Their selection is based on the idea that their experiences give them the ideal background for understanding what the families they serve experience as they access care for their children within a complex service system. The subcontract partially funds several *Hawaii Families As Allies* supervisory and administrative staff statewide who perform such important tasks as developing workshop curricula, providing administrative and fiscal oversight for the subcontract, and representing the family perspective on the Governing Council and on various state-level bodies. In addition, there are five full-time staff with the *Hawaii Ohana Project*, including:

- Two parent partners, who conduct workshops, facilitate support groups, and provide technical assistance to families and service providers alike;

- One data collector who conducts interviews on parent and youth satisfaction with services and handles other family-related data tasks; and

- Two family/professional trainers who participate in developing training curricula for case managers, therapeutic aides, and individualized service planning, and conduct training in these topics, both within the project area and in other parts of the state.

Workshops, held at places and times convenient for families, have been particularly effective in reaching a broad audience (including service providers) and imparting practical skills. Examples of workshop titles have included: Serious Emotional Disturbance in Children and Adolescents; Impact of Emotional and Behavioral Disorders on Families and Coping Strategies; Behavior Intervention for the Child with Serious Emotional Disturbance; Attention Deficit Hyperactivity Disorder in Children and Adolescents; Empowerment Through Parental Record Keeping; Why Managed Care?; Effective Communication and Successful Negotiation; Wraparound Process: Encompassing All Life Domains; and Nomination, Screening, and Evaluation. An additional three workshops are structured around a videotape series by Richard Lavoie on issues related to learning disabilities and skills needed by children for social success. A comprehensive 10-session course is also offered for parents and primary caregivers.

In order to further foster family participation, the *Hawaii Ohana Project* has also actively supported the development and operation of Community Children's Councils. Mandated by a federal

consent decree, 16 such councils throughout Hawaii worked with the state departments responsible for education and child and adolescent mental health to improve services for youngsters with serious emotional disturbances. Community Children's Councils are designed to bring concerned family and community members together with service providers to collaborate on improving local systems of care, with family representatives required to comprise at least one-third of the membership. The *Hawaii Ohana Project* provides extensive clerical support (such as maintaining mailing lists and distributing meeting announcements) and technical assistance to the two local Community Children's Councils for Leeward Oahu and Waianae Coast. The project also supported 16 Community Children's Councils by providing $1,000 to each of them to cover start-up costs. In addition, stipends were provided for parent members for the first few months until the State began to support this effort. This laid the groundwork for similar replication activities in other parts of the state, since Community Children's Councils provide a mechanism for family and community input and participation that is essential in developing and maintaining local systems of care.

The *Hawaii Ohana Project* has also put considerable effort into training and technical assistance in implementing individualized service planning (often known as "wraparound") in a way that maximizes family involvement. The individualized service planning process promoted by the *Hawaii Ohana Project* empowers families at the practice level. The family, in collaboration with the child's lead case manager or care coordinator, develops a Child and Family Team that, ideally, has a membership of whom at least 51 percent who are not service providers but rather people who are naturally involved in the life of the youngster (friends, relatives, neighbors, clergy, etc.). This Child and Family Team has access to flexible funds, which can be used for a variety of creative, non-traditional supports. It is felt that if fully implemented, this approach has the most potential for creating service systems that are truly family-driven and maximally responsive to family strengths and needs.

What Is Working or Not Working

The efforts of the *Hawaii Ohana Project* to foster greater family input in the development of policies, procedures, and programs have been quite successful. Family representatives are active on the Governing Council and its subcommittees, on Community Children's Councils, and on state-level consultative bodies. They have also had an impact by helping ensure that policies, procedures, and programs are more family-friendly and, therefore, more effective. One key factor has been the provision of stipends to help family representatives cover such costs such as childcare and transportation in support of their participation on various committees.

Another indication of success is the positive feedback from the many families and service providers served by parents employed through the *Hawaii Families As Allies* subcontract. Hundreds of family members and dozens of service providers have attended *Hawaii Families As Allies* workshops that provided them with skills and the knowledge of a broad range of topics related to serious

emotional disturbances. It is important to the success of these workshops that they have been designed to present information at a basic, easily understood level. The skills and knowledge gained have empowered many family members to become much more involved in planning, implementing, and monitoring services for their own children, and also to provide valuable input through membership on Community Children's Councils and other consultative bodies at the state and local levels.

The duties of *Hawaii Families As Allies* parent partners also include organizing and facilitating parent support groups. However, it has been found that most parents prefer not to attend formal support groups, largely because local residents are more comfortable discussing their problems when they meet in informal settings, during the natural course of daily life. The parent partners have therefore adapted their workshops to include a discussion session at the end, which tends to lead to the development of mutual support relationships as participants exchange and discuss their experiences.

Another area of success has been the training provided by *Hawaii Families As Allies* staff members to case managers and therapeutic aides. The training curricula developed by the *Hawaii Ohana Project* include modules on a variety of topics that are important for working with and involving families in the context of a particular community. These topics include behavior monitoring and encouragement; crisis stabilization; confidentiality and consumer rights; ethical codes of conduct; and child welfare reporting requirements. Because these curricula are based on systems of care guiding values and principles, they have been adopted for use statewide. Those who successfully complete the training are credentialed by the State Department of Health; their agencies can bill the state for work performed. *Hawaii Families As Allies* staff members have trained several hundred individuals to provide services in their own communities, helping to relieve a severe shortage of case managers and therapeutic aides in many areas. There have also been frequent reports of trained local paraprofessional staff being better able to establish close and effective working relationships with families than professionals from outside the community, due to their knowledge of local strengths, practices, and resources.

As noted above, this "wraparound" process is designed to empower families to play a very active role in planning, implementing, and monitoring services. In practice, however, the process has not been as widely adopted as was hoped, even though the *Hawaii Ohana Project* has made available substantial flexible funds for use by Child and Family Teams. In addition, training events focused on building skills and knowledge for effectively participating in a collaborative, individualized service planning process for hundreds of family members and service providers. Major impediments include case managers (the key personnel for initiating and facilitating the process) feeling too busy with other tasks, other service providers being unable to attend meetings due to scheduling conflicts, and school and agency administrators not being willing to commit resources (many are uncertain that the process will yield the promised benefits). One solution being implemented by

the *Hawaii Ohana Project* is the hiring of "wraparound" facilitators familiar with the local service system who can help to schedule and facilitate meetings and monitor the implementation of agreed-upon services and supports. It is expected that successful demonstrations of this collaborative process will persuade increasing numbers of families and service providers to participate.

Although there are a variety of bureaucratic and other roadblocks to strengths-based individualized service planning, the *Hawaii Ohana Project* remains committed to the process because experience has shown that it really can enhance effective family involvement and improve outcomes. As one parent remarked, "With wraparound, communication happens, the family is involved, and it's strengths-based with everybody on the same line knowing what the consequences are and what will take place. As parents, we are pretty sure of what would work and what would totally not work for our children. The process is really about developing a complete picture and thinking together creatively about the child and family needs."

After experience with the process, another parent stated:

> "I have found there are real successes in getting the players in my son's life, like teachers and agency staff, to work together. What we have been doing for the last three or four weeks is meeting every Wednesday, using it as a wraparound process training, so we are all learning a lot. We think of what we can try, try it, and we don't shut our minds to any possibilities. I see it working because we are hearing more Positive answers now, and seeing more resources available."

On supports received from one of the *Hawaii Families As Allies* parent partners, she added:

> "It has also really helped to have the input of a parent advocate. She has the experience of being a parent, and it really helps to have another person with you, so it doesn't seem overwhelming. It balances out, and gives you support so you know you are not alone."

IMPLICATIONS

The experiences of the *Hawaii Ohana Project* with efforts to involve and empower families strongly suggest that:

■ Family members should be involved in the design stage of all grants and programs.

■ Family members should be supported (with stipends or salaries, training, etc.) to represent the family perspective on committees and work groups at the policy and program levels of systems of care.

■ Family members should be trained and supported to play leading roles in the strengths-based individualized service planning process for their own children.

■ Family members should be recruited and trained to fill as wide a range of positions as possible, including parent partners/advocates, trainers, data collectors, and direct service providers.

Evaluation: The Measure of All Things

The Community Wraparound Initiative
Broadview, Illinois
Tim Gawron, Mary McCormack, and Janet McKelvey

A major feature of system change efforts at the *Community Wraparound Initiative* in Illinois is the design and use of evaluation as a catalyst for change. This proactive, dynamic vision of evaluation evolved during the life of the Initiative and represents one of the essential lessons learned during the grant. Evaluation must be coherently conceptualized, contextually relevant, carefully explained, consistently reported, and constantly acted upon. In short, evaluation must animate the system.

In February of 1994, the *Community Wraparound Initiative* received a grant from the Center for Mental Health Services. The site is located in the near-west suburbs of Chicago and encompasses Proviso Township and sections of Lyons and Riverside Townships where the population base is roughly 280,000 with a higher incidence of Medicaid-eligible families in areas closer to the city. More than half of the families receiving services through the Initiative are single-parent households headed by women. The Initiative is comprised of three not-for-profit agencies (two representing mental health and one representing child welfare), three special education cooperatives, the Illinois Federation of Families, and two local mental health commissioners. Core membership also includes representatives from the State of Illinois Department of Human Services/ Office of Mental Health, Department of Children and Family Services and the Illinois State Board of Education. Initially, none of these entities was engaged in comprehensive evaluation activities, as data collection was limited to basic encounter information.

The *Community Wraparound Initiative* began introducing evaluation in the form of standardized instruments into each of the participating agencies and cooperatives as a part of the grant program. The package of instruments included elements required by the national evaluations and an additional set of questionnaires meant to expand the documentation of the process and outcome of a family's experience with services and educational outcomes. Initially, our evaluation process simply consisted of administering questionnaires and sending data to the national evaluation contractor at the required intervals. While this arrangement placed the Initiative in compliance with grant regulations, it did not create a local sense of ownership of the data, nor did it allow us to learn from the direct application of the findings. To bridge the disconnect between data collection and use, the *Community Wraparound Initiative* implemented a redesign of its evaluation early in 1998, prioritizing the creation of a locally responsive system focused on a process of continual learning from the data.

THE REDESIGN

In order to create the new *Community Wraparound Initiative* evaluation component, several pieces had to be put into place. The global plan for reorganization was conceptualized as follows: First, procedures around handling data in-house were revised to ensure data integrity. Second, stakeholders and relevant participants were identified, engaged or re-engaged. Third, forums for returning data had to be created at various levels. Finally, learning from the analysis of data was used to help think about sustainability of the Initiative.

Procedures for Handling Data Within the *Community Wraparound Initiative*

Reorganized Filing System

The first procedural shift in the evaluation redesign focused on the Initiative database and filing system. Previously, files were organized by family name and/or child entrance criteria. Classification by instrument afforded more effective and efficient data loading, and data cleaning and analyses were simplified. Reliability checks were also instituted.

Systematic Reporting to Stakeholders and Families

A standardized plan was developed for the generation of reports meeting the needs of various participants, e.g., monthly reports on current numbers of children and families participating in the Initiative, bi-monthly productivity reports for clinical and educational managers regarding workload indicators.

Reorganization of Roles: Site Evaluation Manager, Data Collection Manager, and Parent Evaluator

By separating out the functions associated with data collection and loading (Data Collection Manager) from data cleaning, reliability and analysis (Site Evaluation Manager), roles were established which highlighted any unique skills required. This reorganization of effort increased the productivity of the team and lent itself to a more rigorous analysis of the process of evaluation, including the identification of challenges, strategies and follow-through on tasks. Another feature of the redesign was the creation of the role of Parent Evaluator. The senior Family Resource Developer filled this position. In this capacity, he/she develops queries pertinent to a family's interests and is involved in holding parent focus groups, training staff, educating stakeholders and ensuring family involvement in evaluation activities.

Identifying Stakeholders and Avenues for Data Return

Open Discussion with Providers, Managers and Families About Their Data Analysis Priorities

Meetings were held during the first month following the redesign to allow key stakeholders to become familiar with the evaluation team in their new roles. These meetings provided a forum in which the evaluation team could establish priorities with the stakeholders regarding their information needs for day-to-day management and clinical decision-making, as well as for deeper analysis and exploring trends.

Education of Stakeholders About the Instruments

The training for new staff, as well as stakeholders, provided by the evaluation team highlighted the clinical decision-making supports to be found in evaluation instrumentation.

Open Discussion Regarding the Process of Gathering Data and Supplementing Formal Tool/instrument Investigation with Meaningful Qualitative Data

Initially, discussion focused on identifying evaluation instruments and analysis, which could provide a picture of the site, families served and impact of the service providers' efforts. Once these were identified, this led to further dialogue about the role of qualitative information regarding the experience of children and families. In addition, the functioning of child and family teams and the changing role of the provider in "filling out the picture" of the Initiative in the formation of the system of care at the site was explored. Conversations about how care was provided prior to and since the Initiative led to discussions about the role of families in partnering with agencies and school systems. From a change process perspective, capturing the subjective experience of staff and families as their roles in agencies and schools changed was identified as very useful information. The information gained from these discussions could help other communities planning to adopt a system of care approach to service delivery.

Creating Forums for Returning Data

Family Focus Groups

As part of the redesign, the evaluation team held focus groups for families. This forum was initiated to deepen the engagement of Initiative families with evaluation and to provide information to families regarding their own individual data as well as aggregate findings. Another aim of these groups was to elicit the family perspective when examining the meaning and value of the evaluation findings. In the future, these Family Focus Groups will occur on a quarterly basis. Also, clinicians will discuss child and family-specific data reports with individual families during the regular course of providing service.

Agency Focus Groups

Again, to engage agency staff more actively in the evaluation process, Agency Focus Groups were held to allow staff to receive individual and aggregate information about families involved in the Initiative and with whom they work. This process heightened staff interest in more timely analysis and feedback so that they could gauge the relation between their efforts, the team formation process, and the functional shifts identified in the child and family.

Interagency Training Sessions

In addition to the focus groups, agency staff were retrained on all evaluation instruments. A plan was developed for providing ongoing training for existing staff as well as for new staff as hired. Although all new staff are individually oriented and trained when hired, additional group training helps to ensure that there are no individual differences in data collection procedures. These efforts help staff feel supported as they integrate evaluation activities into their service provision.

Contributions to Local Organization Newsletters

To establish better communication linkages with community agencies, the evaluation team promoted their availability to collaborate and submit articles for local publication in organization newsletters and bulletins. An article about the family focus groups was submitted to the *Illinois Federation of Families Newsletter*, and other evaluation data was submitted to the *Community Wraparound Initiative* Newsletter. More submissions are forthcoming.

Collaboration between Initiative and the State of Illinois Department of Human Services/Office of Mental Health Research Unit

Planners and policy makers are keenly interested in clear approaches that yield sound, effective, and consistently measurable results. Throughout the state, the process of moving from intuition-based clinical decision-making to an information-based process is occurring at multiple levels. The *Community Wraparound Initiative* evaluation team collaborates with the Department of Human Services/Office of Mental Health to help with furthering the implementation of evaluation practices system-wide.

Linking Data and Plans for Sustainability

Linking Evaluation with the Implementation of Management Information Systems Within and Across Entities

As part of the evaluation redesign, the previous Site Evaluator moved to the newly created position of Management Information Systems Director at one of the key stakeholder entities in the Initiative. Her role was to implement a software system that would capture demographic, clinical and outcome information, service planning and utilization data as actuarial and billing information and to train clinical, clerical and administrative staff as they shifted to this new system. An essential element of implementation was developing ownership across all levels of the change process, the software system being a part of that whole. In order to accomplish the goal, a Management Information Systems team was created drawing on representation from the various staff levels within the agency. This team planned, organized, presented, shaped and helped evaluate the implementation, thus providing in-house technical assistance using the peer-mentor model. Once implemented, this software system would allow for easy and immediate transfer of information among participating entities. Of major significance to the *Community Wraparound Initiative* stakeholders is the system's ability to incorporate quality assurance indicators and ensure documentation along the lines of the Joint Commission for the Accreditation of Healthcare Organizations and Commission on Accreditation of Rehabilitation Facilities accreditation processes.

Inclusion of Evaluation Instrumentation as Part of Management Information Systems

As part of the software system installed at *Community Wraparound Initiative* entities, evaluation instrumentation is included and all agency staff is trained in its use. The system has the ability to include self-designed tools such as the capacity to analyze wraparound plans as part of the clinical process. As decisions are made regarding which national and site evaluations will be maintained after the grant, the appropriate instrumentation will be identified within the information system itself.

Use of System of Care Findings to Improve Programming, Identify and Address Gaps in Service, and Make Continuous Quality Improvement

Once the software system is fully implemented, the stakeholder entities individually or collectively can analyze the data to identify trends in service delivery. The system can be set to identify patterns of utilization so that bench marking on appropriate distribution of resources can be determined. Cost accounting can be immediately determined in the aggregate or by individual case. These systems capacities will provide information that can redefine program elements as entities collaboratively develop services.

Use of Evaluation to Identify the Discreet Impact of Elements of the System of Care

The *Community Wraparound Initiative* continually analyzes data locally. Significant decreases in problematic functioning, as detected by the Child and Adolescent Functional Assessment Scale, for example, have led to discussions and hypotheses regarding the role of the Family Resource Developer as impetus for the improvement. The Family Resource Developer position is a parent who has a child with serious emotional disturbance, who acts as advocate, support, and liaison for the identified child and her/his family in the Initiative. A qualitative study is being developed now to determine the impact of the Family Resource Developer on service outcomes. *Community Wraparound Initiative* views this role as one of the real service transformations that the Initiative has created. This is one example of how the site uses qualitative measures and methodology to expand understanding about how systems of care emerge.

One of the goals of *Community Wraparound Initiative* is to help the participating entities become "learning organizations," which comprise five disciplines:

- *Personal mastery* — learning to expand one's personal capacity to create desired results as well as organizational environments, which encourage all members to develop toward the goals and purpose they choose;

- *Mental models* — reflecting upon, continually clarifying and improving our internal pictures of the world and seeing how they shape our actions and decisions;

- *Shared vision* — building a sense of commitment in a group by developing shared images of the future we seek to create and the principles and guiding practices by which we hope to get there;

- *Team learning* — transforming conversational and collective thinking skills so that groups of people can reliably develop intelligence and ability greater than the sum of the individual members' talents; and

- *Systems thinking* — a way of thinking about and a language for describing and understanding the forces and inter-relationships that shape the behavior of systems.

Increasing individual personal competence helps create a substantive vision that can be shared with others; this, in turn, develops a group's readiness to undertake systems-related change processes, which is key to the success of creating and sustaining a system of care. Central to all of these processes is the ability of evaluation to create an environment for continual learning, refinement and evolution. The *Community Wraparound Initiative* has sought to include these principles in the redesign of our evaluation process, as well as the development of our system of care.

Integrated Evaluation and the Development of Systems of Care

KanFocus, Parsons, Kansas

Jim Rast, Project Director

Program evaluation can be a burden to be endured in order to receive federal and other outside funding. On the other hand, it can be a critical tool in planning, developing, fine tuning, and sustaining the implementation of systems of care. When evaluation is an integrated element of system of care development from the beginning, it will enhance quality at every level, increase local, state, and federal collaboration, and improve the prospect of future funding. Information and data driven strategies at this level are more than the evaluation of a single program. Integrated system of care evaluation can become a catalyst for system of care development. During the community assessment and planning process it will provide information necessary to develop programs that fit the local community. Developing a common vision and meaningful outcomes will build collaboration among community leaders and providers. Gathering timely information (data) as part of the individual assessment and service planning process will assist individual child and family wraparound teams to more effectively design, implement, and fine-tune service plans.

Integrated system of care evaluation will continuously monitor service process and outcomes to improve effectiveness and cost efficiency. Communities can also use it as an applied research tool to compare the effectiveness of different approaches and programs. The result should be a system of care with continuously improving quality and the flexibility to adjust to the evolving status of the community and families. Concurrent assessment of service components and community resources can provide for more effective and cost efficient decisions on resource allocation. Sorting and utilizing the data at the level of individual staff is a good basis for staff evaluation and development plans. The outcome information collected through integrated system of care evaluation can be a powerful marketing aide to inform local, regional, state, and national audiences. It can be a primary determinant of the success of marketing to sustain funding for services.

LESSONS LEARNED

A developing form of integrated system of care evaluation is a central component of the Kan Focus effort to develop rural systems of care and has had a dramatic impact on system design, implementation, revision, and sustained funding. Many lessons have been learned through the development of this integrated system. This paper briefly discusses three of these lessons and describes a sample of the examples of each lesson. The three lessons are:

- **Community Assessment can be an important tool in planning and developing successful systems of care.**

- **Integrated System of Care Evaluation can be a critical instrument for fine-tuning the development of systems of care.**

- **Reporting and sharing the outcomes of integrated system of care evaluation can be an effective strategy to sustain the development of systems of care.**

Lesson One. Community Assessment can be an important tool in the preparation and development of successful systems of care.

Integrated system of care evaluation combines quantitative (means of what was done and accomplished) and qualitative (how it was done) data from a variety of sources to describe the overall system of care and its individual components. One valuable source of information is the community assessment. This process is a way for communities to come together to assess current outcomes for children and prioritize areas for improvement. It further provides opportunities to assess the current strengths and resources to address these priorities. The problems facing communities are complex, the strengths and resources of communities are unique, and the visions and pathways to improve the status of its children will also be unique. To develop community visions and plans that will work for a community and to address these in effective and cost efficient ways, it is important to integrate the efforts of families, community leaders, service providers, informal and protective supports, and financiers in ways that work best for each unique community. Well-informed planners, staff, advocates, parents and youth will not only develop better plans for their communities, but will be positioned to obtain larger shares of resources available from outside the community. Community assessment may influence system of care development in a number of different ways (Rast, 1998). Three of these are described below.

Assessing outcomes for children is an effective strategy for prioritizing community goals for children. In 1989 Kansas recognized that the rate of long term mental health hospitalization for children (and adults) was too high. Steps were taken to reduce hospitalization (gatekeeping and diversion) and increase community based alternatives through mental health reform. This was an example of outcome assessment that had dramatic influence on system of care development. An initial Kan Focus assessment provides another example of using outcomes for children to prioritize system development plans. During the initial planning for the grant, staff and parents had given a low priority to the need for specialized services for children who had been sexually abused. Figure 1 shows risk data for the initial 100 children served through the Kan Focus project. This graph shows that almost 40 percent of the children entering the system of care had been sexually abused. When this data was shared with the community teams, the priority

for specialized services was increased. This led to a 400 percent increase in service capacity to provide specialized support for these children. In addition, it led to development of a task force to address this issue on a community level and the creation of two sexual abuse advocacy centers in the region.

Figure 1

Child Risk Factors
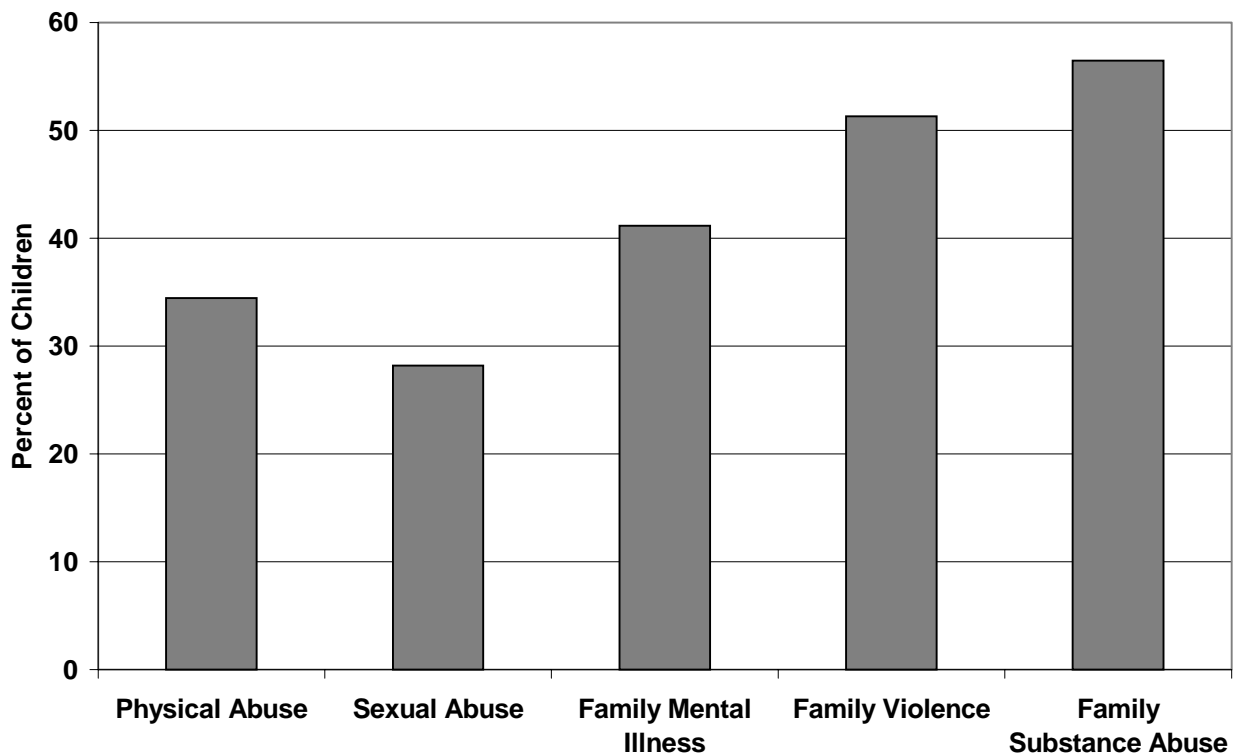
Community assessment can identify risk factors to target early intervention strategies to reduce the incidence of serious emotional disturbance.
One lesson learned through implementation of the Kan Focus project is that providing services after children reach severe levels of impairment can not reduce the incidence of children who have serious emotional disturbance. Community teams in southeast Kansas have implemented Communities that Care (Catalino and Hawkins, 1993) risk assessments for substance abuse, school failure, delinquency, and violence. These assessments are one component in the overall integrated system of care evaluation strategy and have identified key risk factors for serious emotional disturbance for some children. Figure 1 shows the high rates of mental illness, violence and substance dependency in families of children with serious emotional disturbance. Based on this data, Kan Focus developed an early intervention component (Project Before) that provides family-centered support for families in which at least one parent or caregiver has mental illness

or substance dependency. This program has produced significant positive results for the children and parents (Rast, 1997). This same strategy is being used to develop the collaborative juvenile justice plan for these communities. Through this process, risks are being prioritized to develop early intervention programs to prevent juvenile crime and violence. The collaborative nature of this process is building strong links across systems to reduce fragmentation and gaps in supports for these children and families.

Community assessment can be an effective tool to prioritize resource development and deployment. A service component survey was used to identify strengths and needs for service capacity during the initial planning process for the Kan Focus grant. This assessment component engaged families, providers, and community leaders in a process of estimating the need for various services and supports. The estimated need was compared to current resources to determine priorities for resource development. This process was the basis for initial service development. In addition, this process identified current strengths in the system. For example it was determined, that the Family Life Center provided the most comprehensive services around child sexual abuse. Based on this finding the director of this Center was engaged to coordinate and provide professional leadership for the development of these services across the region. This process also identified effective adventure based psychosocial programs at Families and Children Together and one to one aides and crisis response programs at Four County Mental Health Center. Based on this assessment, the expertise of these programs was used to design and develop programs throughout the 13 counties and to train staff to implement them. Another component of this assessment was a geo-mapping of resources. The left panel of Figure 2 shows the location for out patient and targeted case management services at the time the grant was funded. The assessment revealed that transportation was a primary barrier to services for many rural families. For this reason, 5 new service locations were established during the first three years of the project to better serve people where they live (see right side of Figure 2).

Figure 2
Geo-mapping of Resources
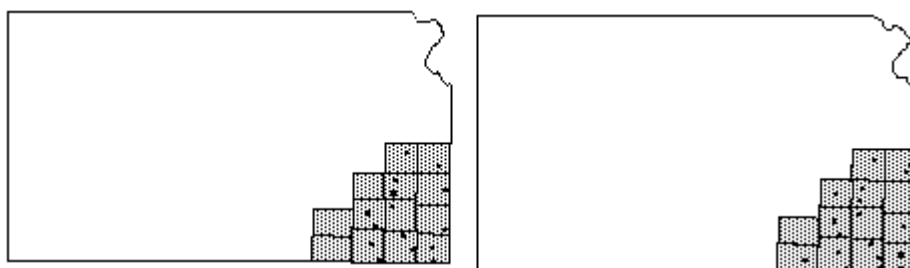
Lesson Two. Integrated System of Care Evaluation can be a critical instrument in the fine-tuning of developing systems of care.

The data from an integrated system of care evaluation system can be used for continuous quality improvement. Good current data can assist communities in determining what works and does not work based on the individual characteristics of child, family, provider, and service. This can create an effective learning environment in which system of care partners determine what works best in their community and use this information to shape system change. One benefit of a good integrated system of care evaluation system is ready access to information systems for managers, staff, and consumers. Leaders and communities that have good information are becoming the most influential players in the current outcome and results based climate. When information systems link demographic information, diagnostic assessment, service process, and outcomes, it becomes possible to measure and report the differential cost effectiveness of various services for different groups of people. There are many examples of how integrated system of care evaluation has influenced the developing system of care in southeast Kansas. It has provided information to the local and regional coalitions that have lead to prioritization of system wide efforts to implement Child and Adolescent Service System Program values. It has provided information for managers and supervisors that have led to continuously improved services.

Integrated system of care evaluation can provide system data to prioritize system values development. At the system of care level, yearly assessments measure how well the system meets critical Child Adolescent Service System Program values. These assessments are done through a system of care survey completed by families, providers, and community leaders. The results of these surveys are shared with the local and regional teams. Figure 3 shows the results of these surveys. Following the first year of the grant, the results of this process showed that cultural competency was clearly the weakest area of development. When this data was presented to the regional coalition, cultural competency was established as the highest priority goal for systems values change. Similarly after year three, utilization of informal resources was added as an assessment category. The first year this category was assessed it received the lowest overall rating and based on this has been a high priority for coalitions since that time. Coalition involvement and ownership of the assessment process has focused attention on implementing Child and Adolescent Service System Program values throughout the service delivery system. Feedback on how well the efforts are working has increased motivation to do "whatever it takes" to meet these values.

The integrated system of care evaluation process in southeast Kansas has also provided information for supervisors and managers that have resulted in continuous quality improvement. For example, a comparison of diagnostic patterns at different service locations and among different therapists found a significant variation in practice. Focus groups and meetings with these diagnostic staff surfaced a strong resistance to labeling children as seriously emotionally disturbed. The disadvantages of labeling were compared to the reality of gate keeping to accessing state and federally funded community

based services for children. The advantages of those services for children were described and parents discussed their perspective of the balance between labeling and community-based services. The data from integrated system of care evaluation identified the problem area, which led to more consistency in this aspect of service delivery.

Figure 3
System of Care Ratings
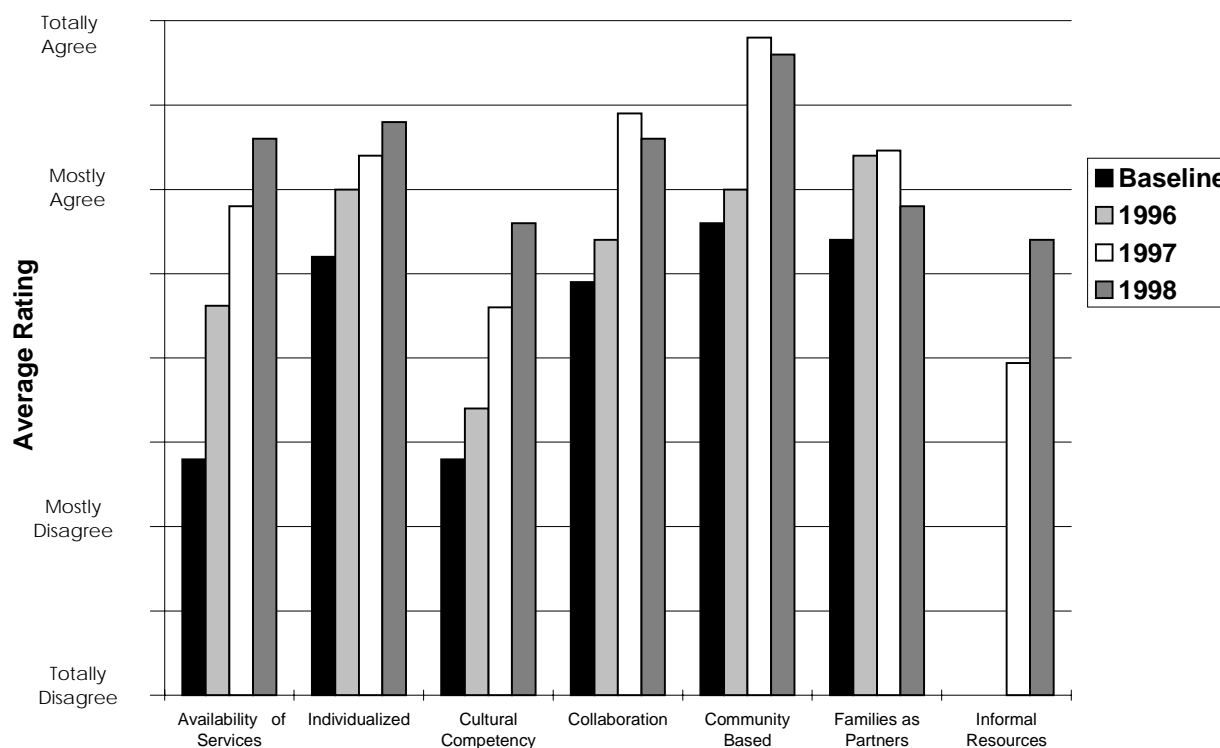
Program evaluation has also resulted in improved performance by staff. Individualized family plan reviews for the early intervention program revealed few goals that directly addressed the development of protective factors for the children. Follow-up determined that the home visitors were so engrossed in helping families meet basic needs, that the needs of children were being put off. This caused us to re-evaluate and change the overall planning strategy, to include specific goals for children in all plans.

The case review process also identified other areas for quality improvement. A review of the written plans for children with serious emotional disturbance revealed inconsistency in the use of strength-based approaches. Some plans were primarily deficit-based while others were so strength-based they included no needs. This information became the basis for focus group discussions. These were followed by a change in forms and training which resulted in higher quality strength-based plans. The case review

process and focus groups with families and providers had similar impact on family-driven (families selecting their own teams and plans) and specificity of implementation plans.

Integrated system of care evaluation outcome data can help pinpoint areas of the system that are not working well. The outcome data from the integrated system of care evaluation can also be a valuable tool in the development and improvement of the system of care. Outcome data for the project showed significant reductions in unexcused absences, suspensions, and expulsions in the first six months after entering services. Other data showed improved school attendance and grades. This data also reveals a small group (less than 10 percent) who were going to school less than 50 percent of the time at the time of intake, but for 57 percent of these children the initiation of services did not impact school attendance. The data shows that children who attend school regularly and who are enrolled in services get better. It also shows that if children begin attending school regularly they get better. For those children who did not begin attending school regularly, however, there was no improvement. In fact, all clinical symptoms across their whole environment got worse. Based on these findings, community teams met to come up with ways to get these kids involved in school. One step was a large region wide school based wraparound training. Other steps included more support in the schools, increased linkage of schools and community based services. The overall result (as seen in the pie chart on the bottom of Figure 4) has been an improved success rate for these children and the whole system of care.

Figure 4

School Attendance First 125 Kids

87%
Regularly
(More than 75%)

7%
Infrequently
(less than 50%)

6%
Frequently
(50%-75%)

Intake

Infrequently
57%

Frequently
43%

Regularly
0%

One Year

School Attendance

N=282

87%
Regularly
(More than 75%)

6%
Infrequently
(less than 50%)

7%
Frequently
(50%-75%)

Intake

Infrequently
18%

Frequently
12%

70%
Regularly

One Year
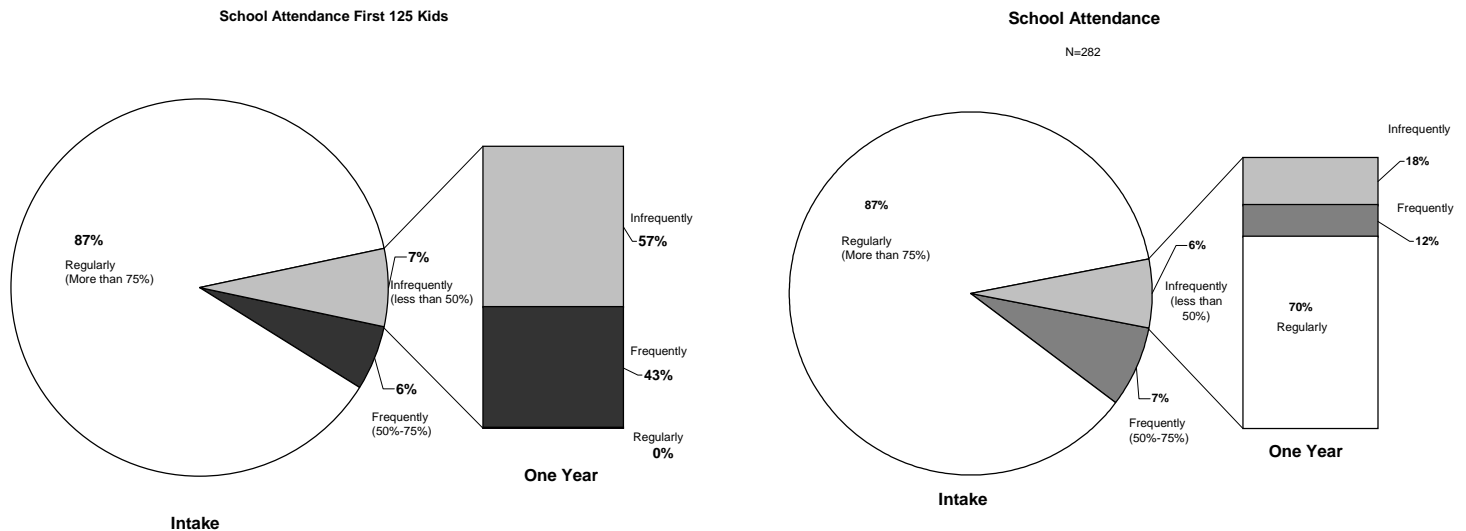
Lesson Three. Reporting and sharing the outcomes of integrated system of care evaluation can be an effective strategy to sustain the development of systems of care.

Integrated evaluation information can be a valuable tool for managers to sustain the development of systems of care. This information can be used to evaluate the cost effectiveness of various programs and services. The information from integrated system of care evaluation will provide quantitative and qualitative data on the performance of the staff in the system of care and can be the basis for a performance evaluation system. An integrated evaluation system can provide timely outcome data for funders, planners, and community leaders to build confidence within the communities and improve financial sustainability.

Integrated system of care evaluation can improve program cost efficiencies. In southeast Kansas, various components of integrated system of care evaluation have been used to improve the cost efficiency of services. Supervisory case review and outcome monitoring showed that children were often maintained at more intensive levels of services than outcomes predicted. Interviews and focus groups determined that families often liked the support, that case managers were over protective in the fading process, and that termination goals were not being mutually established early in the process. The result was a less than optimal expenditure of resources. As the situation was addressed the resources were made available to more children and families. On the other hand, funding streams may cause services to be provided to maximize money instead of to best support children. For example, the Kansas Medicaid funding rates for some of the system of care services (case management, outpatient therapy, and psychosocial groups) are set high enough that profits are likely. Other services (one to one mentoring, psychiatry, and wraparound facilitation) do not pay the basic costs of these services. Integrated system of care evaluation data clearly shows overuse of the profitable services and efforts to reduce or restrict use of the non profitable ones. As states and communities develop funding mechanisms, it is critical to understand the fiscal incentives and disincentives, which produce services that match the values of the system of care. Fiscal incentives may be the most significant factor in effective system change.

Integrated system of care evaluation can improve collaboration and community support. Through the community assessment process the early intervention project determined goals that were meaningful to the community. Reporting on the progress to meet these goals has resulted in improved collaboration. The primary outcomes developed through the advisory committee and focus groups early in the project included ensuring appropriate health care for the children and mothers among others. As the project progressed we have measured these outcomes and reported them to the community on a regular basis. Traditionally the health focused home visitors have had difficulty engaging families with significant mental health and substance abuse issues. They were resistant, however, to referring them to the "mental health" program. One key reason was a fear the families would not receive needed health care services. Figure 5 shows data on health and behavioral health service utilization. The

black section of each column shows the percentage of children or parents receiving that service at intake. The white section shows the increase at the end of three months. As we have shared this health care utilization data, health care staff have seen that, we are sincere about prioritizing health care and that our mutual collaboration means that more families are now getting to health care services than before. This has led to many more referrals and improved services.

Figure 5
Receiving Health Services
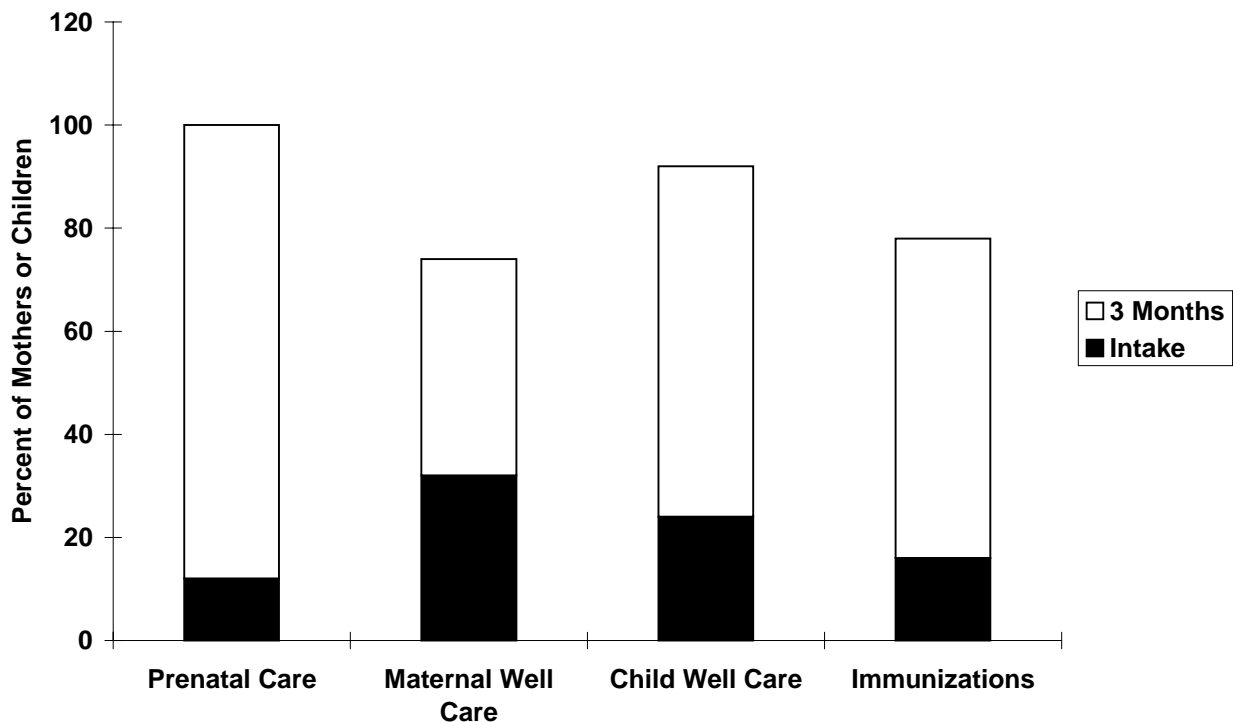
Integrated system of care evaluation data can be used to build support to sustain the development of systems of care. Public presentations and community report cards have been developed and shared with the local communities, state agency staff, and Kansas legislators. This data paired with family testimony has resulted in an increase of over five million dollars a year in funding for mental health services for children with serious emotional disturbance. Copies of these reports are available through the Kan Focus office.

In addition, program evaluation has described unexpected results that have improved community

support. Although there was no stated Project Before goal to impact employment by parents, we took data on employment as both a demographic and risk factor. Single mothers with high risk factors and substance dependency and/or mental illness are reputed to have the least success in job placement programs. Based on the wrap process value of family determination of goals, the single mothers set their own goals of working once a safe environment and basic family needs were met. Within three months over 75 percent of them had (see Figure 6). This has built strong local and state support.

Figure 6
Female Caretakers Working or Going to School
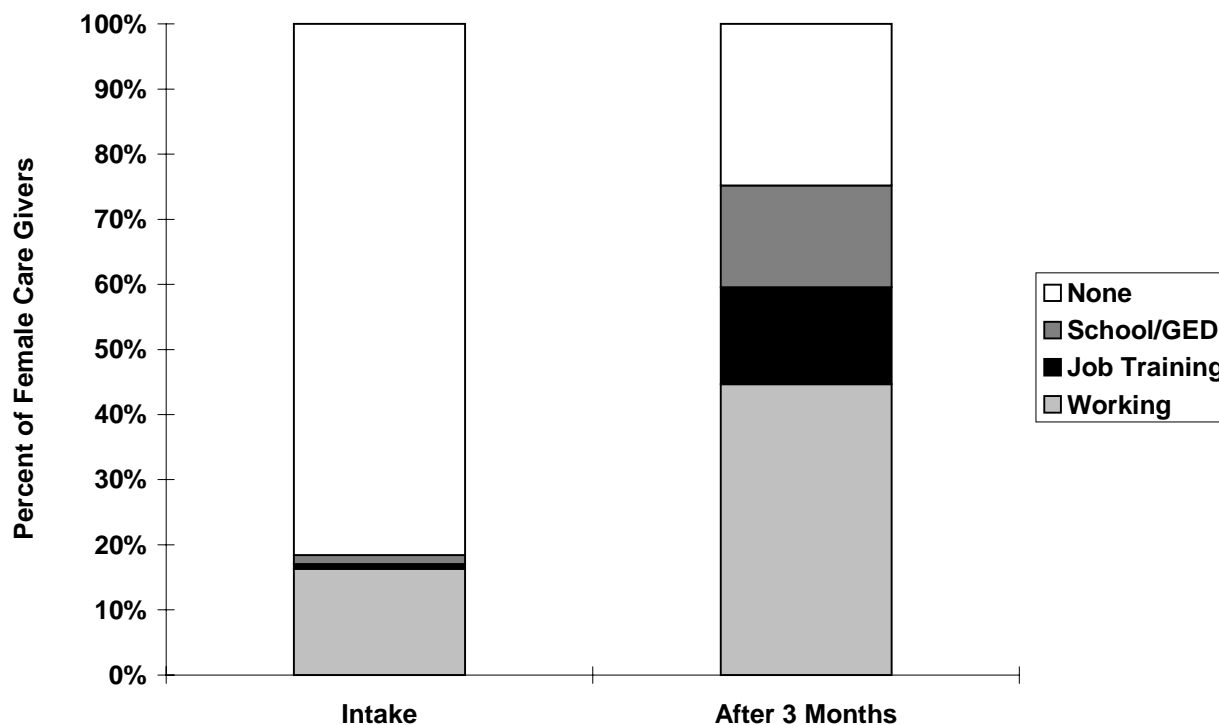
There are many ways integrated system of care evaluation can support the development of systems of care. The data from integrated systems of care evaluation can be an effective navigational tool through the complex issues facing today's communities. This is becoming more important in the current devolution (moving control of programs from the state and federal to the local community level) environment. Without this data many current decisions are made without data and with a poorer prognosis for success. One of the important functions of well-designed integrated system of care evaluation can be assessing the real world effectiveness of various service strategies. Often we are faced with questions as to which community-based service interventions work and which do not. We also do not understand the characteristics of children

(strengths, disabilities, history, and symptoms) or families (strengths, resources, needs, or risk factors) that may predict the types of services and supports which will be most effective. Good integrated individual family and system of care evaluation can help us to begin to answer these questions.

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Parent Advocacy and Family and Children Community Services Support: a System of Care Component

Wichita, Kansas
Shelley Duncan, Director

Parent advocacy and support is critical in establishing a child and family centered system of care. Parent advocates can be very effective in working with and supporting families in a different way than professionals can. In addition, they can help bridge the gap between professionals and families so that both may work in the best interest of the child. Parent advocates have moved our systems to become more family friendly and family focused. They have influenced policy and funding decisions at the local and State level. They have also worked effectively with this project in moving toward a more culturally competent system. The family leadership has been a great support to the project site director and has influenced our constantly evolving system. And we have all learned some lessons about this critical partnership.

In 1994, *Family and Children Community Services (FCCS)* received a grant from the Center for Mental Health Services to serve youth currently in the State psychiatric hospital or at risk of hospitalization. *Family and Children Community Services* serves within Sedgwick County, Kansas, which has a population of 400,000 including the city of Wichita with a population of 350,000.

Family and Children Community Services began in July 1992 following the passage of Mental Health Reform legislation to deinstitutionalize the State psychiatric hospitals. FCCS originally offered only "non-traditional" community based services including case management, attendant care, respite care, in-home therapy, school based therapy, flexible funds, parent advocacy, and crisis stabilization beds. The Federal grant enabled us to build upon the service system already bring developed. Families have been included in the provision of care from the outset. A wraparound model and philosophy was, and is, in place and acts as the guiding force behind the program.

The function of Parent advocacy and support has worn several different faces during our journey to build a system of care in Sedgwick County. Although it has been considered an integral part of the system of care from the beginning, it has sometimes been viewed as a separate service. It began as support for families who had a child with serious emotional disturbance. Families were offered advice and support concerning the needs of their child and themselves. Soon these efforts evolved into a fully staffed program where not only support, but also training was offered to families.

Before Welfare Reform, the parent advocacy and support program had a contract with the state to train parents receiving Aid for Families with Dependent Children. The program worked with numerous single parents who were trained in office work and advocacy. Many of these parents had not been gainfully employed for several years and eventually were successful in finding employment. The advocacy and office skills they learned allowed them a number of options. With Welfare Reform, this function of the parent program eventually ended, but it grew in other ways. Now, the parent advocacy and support program offers parent support groups, one-to-one individual support and guidance, training to families and professionals, educational advocacy, and provision of Medicaid services through the new Home and Community Based Services Waiver for youth with serious emotional disturbance.

The parent advocacy and support program developed based on the needs and energy of the families who were involved. Families were supported and received benefit from their involvement. Their children's rights were being met in a new way. Systems were challenged about policies and practices. Families were becoming more powerful in directing the provision of care for their children. The project site director and other professionals in the community supported the parent program.

The *lesson learned* was that although parent advocacy and support is necessary and integral to our system, it is not enough simply to provide funds to a new parent organization. As in any other organization, the parent leadership needs the support, tools, information, and administrative skills necessary to manage both programmatically and fiscally. Because the parent advocacy and support function was seen as "cutting edge" practice, and because professional staff didn't want to interfere, the parent organization was left to find its own way. After two years of funding the original parent organization, circumstances required *Family and Children Community Services* to cancel the contract. This was a difficult and painful experience for all involved.

The most significant issue, however, was the immediate loss of the parent advocacy and support program that had served a number of families. The project quickly contracted with another local agency which had housed the parent program originally. This agency hired staff from the parent program and a new program was born. The project hired a respected consultant to learn from the stakeholder process about what had occurred, and what the community and parents wanted to happen next. We learned many lessons about what worked and what didn't, before, during, and after the crisis.

WHAT WORKED:

- true collaboration of parents and professionals coming together to define the role of a parent advocacy support program;

- constant communication between the project site director and the parent program leadership;

- clearly defined expectations from both project site director and family organization leader;

- co-locating office space together;

- constantly reminding staff about parent inclusion and involvement of the parent program;

- creating a culture which values and expects parent inclusion, and is constantly trying to improve parent/professional collaboration;

- adequate funding to create a parent advocacy and support program;

- making the difficult decision to terminate the contract with the original parent organization, which meant closing an important program;

- finding a parent "leader" who had the skills and commitment to pick up the pieces and create a new program;

- administrators who encourage thinking outside the box, allowing for creativity and risk taking. Without this, the evolution would have been much, much slower. Failure can many times be a "blessing in disguise";

- agreeing to disagree and developing personal relationships built on mutual respect and trust;

- conditional support, with accountability as a condition;

- honest communication even when things get rough;

- keeping politics out of the way of working toward a common goal; and

- keeping children at the forefront of our work and not allowing anything to get in the way of putting them first.

WHAT DIDN'T WORK:

- assuming that grassroots organizations automatically understand the complexities of running a program funded with federal and state dollars;

- not having a clear plan with specific expectations and accountability included;

- assuming that anyone could be a good "leader" — that charisma and commitment are enough;

- not having the support from all involved getting through the difficult times;

- people fearing they couldn't be honest about concerns over the original parent advocacy support program; and

- letting a difficult experience temporarily cause a sense of failure among the agencies involved (fortunately, we helped each other out of this by planning for the future).

We have come a long way. The new parent support advocacy component has been in operation for approximately two years. The Executive Committee of the Children's Mental Health Coalition, which included parents and professionals, decided to continue with the interim agency, which took the recommendations of the consultant's report and began anew. The credibility of parent advocacy and support has been renewed and revitalized. It is more respected than ever. There are now three other parent support entities functioning in the community. While this means competition for limited funding, there is now a collective Parent Information Exchange Network, which is a board comprised of professionals and parents representing each parent support and advocacy program. For the first time, there is an organized and coordinated voice representing the needs of our community and of many diverse parents. There is now hope.

The implications of the lessons we learned are significant for other sites. There were many more things done right than wrong. The likelihood of this experience happening in other sites is slim. Collaborating with parent support and advocacy organizations must be based on an understanding of joint expectations and accountability. Everyone must come to a place where this is seen in a positive rather than a negative way. This could occur in a new site where parent advocacy is just beginning and a "professional" organization is in the funding role. If both sides are not clearly committed to the endeavor it may be fraught with problems. For example, one side may think the other is being unduly demanding or wanting accountability which is interpreted as not trusting or questioning the credibility of the other. The bottom line is that all of us who receive funding must be responsible and accountable. It is better if this accountability is experienced in a positive way and seen by all as a way to support, guide, and direct rather than to admonish, punish, or dictate.

It is likely that the parent support and advocacy component will be at different levels of development in different sites. An absolute driving force must be respect for one another from the beginning. If this is lacking, then a consultant should come in and spend enough time to get the site ready to begin the process. It is a challenging process; particularly for "professionals" who have never been involved in this kind of work with families. Likewise, it is a challenge for families who may have never had this kind of access to power and authority. Both sides should proceed slowly but steadily, and both must appreciate the risks involved. It will likely be a continuous journey.

Another *lesson learned* is that education and training on collaborating with parents should be offered to providers of all child-serving systems. In addition, policy makers must understand the necessity and complexity of the parent support and advocacy component. Local leaders need to educate and inform policy makers about this issue. Frequent communication is key. Policies that support parent support and advocacy are important. However, policy alone cannot make this a success. If there are leaders and champions, a culture that incorporates parent support and advocacy can be achieved in all systems, for all children and their families.

Family/Provider Relationships
Wings For Children and Families

Bangor, Maine

Jackie Ackley

In 1993, the State of Maine received a grant from the Center for Mental Health Services to create a responsive, effective system of care for children in a four-county region in rural Maine. The planning process was carried out by a group of parents and providers from the four counties who came together in the interest of creating this comprehensive system of care for children and families. Grant resources were used to create a new agency that provides case management and advocacy services for children with emotional/behavioral disabilities, now called Wings For Children & Families, Inc. Overseen by a 21-member Board of Directors consisting of 60 percent parent membership, the program provides services for children ages 5 to 21, and their families.

Wings was initially structured to include parents in two ways. Some parents were recruited to serve as members of the Board of Directors, and some were hired to work in partnership with case managers in providing comprehensive, family-centered services. Parents hired by Wings were given the title "Parent Advocate Specialist." While this new family-provider collaboration was exciting, it came with inherent challenges and frustrations on both sides. Family members and providers sometimes disagreed about how collaboration is defined and practiced at the site, and more particularly, how power is shared. More specifically, conflict regarding the appropriate roles of case managers and parent advocates, along with the struggle for equality, control and clear boundaries between the two roles became apparent. These issues were brought forth very early in the development of Wings and we learned the importance of acknowledging and addressing them as soon as possible. The experience taught us that true collaboration would not occur as long as there are power struggles and a lack of a common understanding of collaboration.

Case management was not a new service in the community. The role of case managers at Wings was well defined and understood. Methods used to train Wings case managers consisted of techniques employed by other agencies across the community, but with two unique additions. First the training introduced the philosophy and process of Wraparound.   Second, the addition of parent advocates to the provider team meant breaking new ground in the service delivery system. There were no other programs in existence in the community structured this way, so there were no models to follow. No one knew the "appropriate role" for a parent advocate. As a result, job descriptions for these positions were necessarily vague and would be shaped by the parents who filled those roles.

Once the parent advocates were hired, they received the same training as case managers. Following their training, they were encouraged to begin building relationships with families receiving case management services through home visits. The parent advocate would then assess what role, if any, they would play in the support of and advocacy for each family individually. This approach to role-development, with its many challenges, proved to have a positive outcome. Parent advocates began to define their roles very differently across the program, tailoring their services to meet the needs of the culture (county) in which they worked. Opportunities for cultural competency in the delivery of services to families opened up. However, as these new relationships developed, struggles for clear defined boundaries between the work of the case manager and parent advocate occurred. The problem escalated as parent advocates engaged with an increasing number of families. Early efforts to address these issues included a staff retreat to openly address the problems; workshops on personality styles and differences; training on communication, relationship building and conflict resolution; and exercises to build trust between employees. These efforts were helpful, but often proved to have limited, short-term affects.

The continued growth of Wings as an agency meant an on-going need to hire and train new employees. Veteran employees were asked to define training methods that would address conflicts between the parent advocates and case managers. Parent advocates became active in training new case managers who presented the family perspective, and led exercises that encouraged family-centered, family-friendly practices. Comprehensive training for parent advocates has been expanded to include a focus on the importance of on-going, individual self-reflection and personal growth in providing families with effective, objective support/advocacy services, grief issues, and other issues. The agency has also recognized the need for internal support systems for parents who still struggle with the pressures and challenges of parenting and who now have the added pressure of working within the system of care. Many of them have expanded their roles at Wings and have moved to other jobs within the agency, including data processing, facilitation of wraparound with families, and intake. Parent advocates were also responsible for the creation of a comprehensive information and referral service.

Although our journey has had its share of sharp curves, parent advocates and case managers continue to work toward the goal of true collaboration. Wings parents and professionals have made the commitment to continue working together. We cannot expect other providers, agencies, and systems to engage in this collaborative effort if we admit that we cannot do it ourselves. The commitment from employees to continue working toward this goal is truly the "glue" that has held us together.

Community Oriented Policing Services

East Baltimore Mental Health Partnership
Raymond Crowel, Director

The *Johns Hopkins Hospital East Baltimore Mental Health Partnership* has forged a collaborative relationship between the Baltimore Police Department-Eastern District and the East Baltimore Community for the purpose of helping children and communities affected by violence. Using a program offered by Yale University and the New Haven Police Department as a model, the Partnership and Baltimore Police Department created the Community Oriented Policing Services pilot program. This unprecedented program is an expansion of the Partnership which now includes the community, and has adapted its effort to address the impacts of violence unique to large urban settings where large numbers of children are exposed to chronic, and at times severe, violence. This is especially the case in cities such as Baltimore, where homicides, assaults, drive-by shootings, and domestic violence occur all too frequently. Of the nine districts in Baltimore, the Eastern Police District in Baltimore has had the highest crime rate per capita for the past four years. In 1996, the Eastern District, a 4-square mile area, recorded 2,605 violent crimes, including 68 murders. In 1997, there were 2,391 crimes of a violent nature. In this same time period there were 78 murders in the Eastern District, which reflects a 14.7 percent increase from 1996. On average, each month, there are over 250 reported incidents of domestic violence in East Baltimore alone.

Frequently, when violence occurs in the homes or in the community, the police are usually the first professionals to arrive at the scene. What police officers do or do not do in this situation will leave a notable impression on children who are victims or witnesses to violence. These first contacts with "authority" shape a child's reactions and attitudes toward police, toward the event, and toward violence in general. Traditional police training does not address children's reaction to trauma. Consequently, police officers may not recognize their potential impact on children in such situations, particularly in instances where force is used. Even when officers are sensitive to child development issues, police training does not include information that directs an age-appropriate response to a child's distress. As a consequence, the actions of police may be seen by children as harmful and violent, and in turn contribute to long-term negative attitudes and behaviors towards authority figures in general, and towards police in particular.

Police officers are in an ideal position to provide immediate support to the family and community and to initiate actions that ensure that the community receives the help it needs to decrease the level of violence. Formal support systems, such as mental health, schools, and social services are often not involved in helping victim children and their families until the child's behavior becomes disruptive or self destructive. By this time, several years of exposure to chronic violence may have passed, and compounded with other risk factors to produce a prognosis poor for the child.

The intent of our program is to provide a proactive intervention focused on children (ages 1–17 years) who are at risk of trauma resulting from exposure to violence, assaults, and violence incidental to law enforcement activities. Community Oriented Policing Services focuses on addressing the aforementioned serious problems through the utilization of an innovative and proactive strategy that has spurred the development of police/community partnerships focused on crime prevention and control and on the development of collaborative working arrangements across jurisdictional and professional areas of responsibility.

The primary goal of the Community Oriented Policing Services Program is to reduce the occurrence of violent crime in East Baltimore. The objectives of this program are:

- to bridge the gap between police officers, mental health providers, and the community in order to create a truly coordinated and collaborative community-based effort to reduce violent crime;

- to increase police officers' knowledge of how children react to violence, and increase their appreciation for the potential benefits of collaborative intervention;

- to increase the clinician's knowledge of policing strategies and practices and increase their appreciation of the potential therapeutic value of police authority;

- to intervene in addressing the trauma of exposure to violence and to break the cycle of violence in children who have witnessed or been the victims of violence;

- to develop a community-based approach that is replicable in other designated hot spot areas;

- to provide a flexible on-call support system so that officers, clinicians, and community representatives can team up to meet the unique needs of children and families in a variety of situations; and

- to train members of the community along with the officers and clinicians and allow them to contribute their insights and increase their knowledge regarding the needs of children and community.

The Community Oriented Policing Services Program has been designed to assist police officers in their community policing efforts through cross training, teaming with mental health staff and, most importantly, linking collaboratively with other community resources. The program consists of a multi-level cross-training program, short-term trauma response; and a community-based follow-up to traumatic incidents. Each of these components is briefly described below.

POLICE/COMMUNITY AND YOUTH/MENTAL HEALTH CLINICIAN CROSS-TRAINING COMPONENT

The Police/Community and Youth/Mental Health Clinician Cross-Training Component consists of three levels of training over an 11-week cycle. During each cycle, community forums are held to provide residents and youth with an opportunity to discuss their concerns about violence, learn about the impact of violence on children, and plan innovative approaches to preventing violence in the community. Several one-day cross-training sessions are held to provide a more detailed discussion of the impact of violence and intervention strategies. Out of these one-day training sessions 15 candidates for fellowship training are selected (5 police officers, 5 community members, and 5 mental health clinicians). Finally, the fellows cross-train in a 7-week, 30-hour, in-depth program on child development, the impact of violence on children, and steps toward early intervention. This multi-level training cycle provides considerable opportunity for the community, police, and mental health staff to air their views on difficult issues such as police brutality, community suspicion, and the stigma of mental illness. In turn, this greater awareness will stimulate a greater sense of shared goals in the protection of children at-risk of trauma from exposure to violence. As a result of these opportunities, stronger and more effective collaborations become possible as each participant gains a greater understanding of his/her respective roles.

The training is designed to meet the needs of the residents of Baltimore City and to focus on violent crime such as:

- Domestic violence

- Aggravated assault

- Drive-by shootings

- Homicides

- Car jackings

- Violence in schools

Three to five training cycles take place each year, with all sessions facilitated by a team of co-trainers from the pool of Community, Mental Health and Police Community Oriented Policing Services fellows. Graduating "fellows" then form the core of the trauma and community response efforts of the Community Oriented Policing Services Program.

TRAUMA RESPONSE COMPONENT

The Trauma Response Component is designed to provide police officers with a range of intervention options when confronted with situations that include children who are exposed to and possibly traumatized by a violent event. The officer activates a response consisting of a Police Fellow, Mental Health Provider Fellow, and/or Community Fellow according to family and community need. Once provided with information from the officers at the crime scene, supervisors or officers who have completed the child development training will make a decision to contact the on-call mental health clinician. The clinician, in collaboration with the officer-in-charge of the crime scene, will determine the necessary level of immediate intervention. This response team works with the child, the family, and the community by taking a variety of immediate actions, ranging from consultation to direct on-site debriefing of persons either directly involved or who witnessed the event. Options may include any or all of the following:

■ an immediate intervention by a mental health clinician and community fellow at the crime scene;

■ referral for evaluation and treatment recommendations;

■ referral for automatic follow-up with a school-based mental health clinician; and

■ referral for immediate outreach/home-based mental health and case management follow-up.

Within 24 hours of the initial event a follow-up contact will be made by the police/mental health clinician/community fellow to determine the continuing service needs of the family. This rapid response sets the stage for more involved follow-up with both the family and community.

To ensure the smooth coordination of police and mental health services, the response team will not begin providing services until the officer-in-charge certifies that evidence collection is completed. In addition, to ensure confidentiality and protect the rights of the child, any immediate interventions will require the consent of the available responsible custodian at the scene.

FOLLOW-UP

Follow-up is designed to ensure that both families and communities are actively involved in ongoing support as needed. For families this involves both follow-up sessions by the response team fellows, referrals and/or pro-active linkages to the East Baltimore Mental Health Partnership mental health service. Because a violent event is a catalyst for community change, follow-up activities include community debriefing and action sessions facilitated by community fellows. The objective is both to provide the community an opportunity to talk through their experiences, and to decide on

collective actions necessary to heal the community, resolve disputes, and prevent future episodes of violence in the community. The community fellow will facilitate initial action steps agreed upon by the community.

Each violent event that the Community Oriented Policing Services team responds to creates another opportunity to develop stronger collaborative relationships both within the community and between community, police, and the mental health system. To further facilitate this collaboration a weekly Program Conference provides an opportunity for police, community, and mental health representatives to plan and coordinate appropriate Community Oriented Policing Services Program follow-ups. A weekly joint police/mental health program conference is held to review all contacts made by the Community Oriented Policing Services program. This is an opportunity for continued "cultural" collaboration between police/mental health professionals to problem-solve and develop alternative strategies within the community policing/child development concept. This conference also provides police/mental health peer supervision, reviewing the level and appropriateness of services provided to children and families by Community Oriented Policing Services. In addition to line staff, police supervisors and mental health administrators and a consulting psychiatrist or clinical psychologist attend this meeting.

While the Community Oriented Policing Services program is still in the early stages there are several clear lessons.

Communities have strengths and resources that are often not obvious to systems developers.

While it has always been part of the East Baltimore Mental Health Partnership philosophy of to involve the community at the beginning of our program efforts, we were impressed by the intensity of the community response and surprised by the existence of "community counselors" - neighborhood residents who were engaged in talking to and aiding the child victims of violence. This saved the police department and the mental health system from assuming the role of expert in planning and implementing an "intervention," nor did they have to create a response from the ground up. Community members had ideas, expertise, and experience in addressing the needs. The resulting program incorporated the authority of the police department, the child development knowledge of the mental health system, and the existing work of the community into a single dynamic response to violence in East Baltimore.

As with cross-agency collaborations, there are enormous gaps in the perceptions and considerable distrust between the players.

What started out as a training process on the impact of violence on children's mental health soon shifted emphasis to cross-training each of the participant groups on the perceptions and attitudes toward

violence and one another. Of particular importance in this process were the opportunities for the participants to "get real" with each other about their distrust and why violence has continued to be a problem in the community. The East Baltimore Mental Health Partnership facilitated opportunities for the groups to see the world from a different perspective, resulting in greater awareness and understanding by all. This in turn led to a stronger and more integrated response to community violence, with community members and police officers working together not just around a violent incident, but also in the healing process in the aftermath.

A related lesson is that the process of education and cross training must be continuous. Because the police department and the mental health system have constant staff turnover, we have constantly had to train new-staff in the program. The relative stability of the community members in this process has again proven to be a valuable resource in this process since they are now called upon to assist in training new officers and mental health staff as well as new community members.

Mental health systems are ideally suited to serve as a "facilitator" of collaborative processes.

Our experience with the Community Oriented Policing Services program has demonstrated a unique role for mental health in this process. Both public human service agencies and the community are ultimately concerned with behaviors that are often directly influenced by an individual's mental health. Because mental health professionals have a unique knowledge of the biopsychosocial underpinnings of human behavior, they often play a direct role in addressing these issues. Easy movement between the Police department and various community members afforded East Baltimore Mental Health Partnership mental health professionals the opportunity to identify common interests and bring together the multiple groups who were motivated to address the problems of community violence. This "lesson" is not new, and has its roots in the community mental health centers of the late sixties. It does, however, point to the need for newly developed systems of care to ensure that mental health professionals have broader training and a greater skill level in facilitating these collaborative processes. Clinical training alone is insufficient to build effective systems of care.

Building Systems of Care in a Managed Care Environment

Dona Ana County, New Mexico
Cathy Provine, Director

New Mexico is the fifth largest state geographically and reflects many diverse cultures. Visitors to the state usually understand why it is called "The Land of Enchantment" because of its beauty, both in its landscape and its people. However, various polls consistently rank New Mexico near the bottom of the nation's states as a place to raise children, based on rates of divorce, crime, and high school graduation. These and other factors reflect the larger social issues of poverty and health status.

The New Mexico State Department of Children Youth and Families received a grant from the Center for Mental Health Services designed to radically change a segment of the health care delivery system. The program, originally called the *Dona Ana County Child and Adolescent Collaborative*, is located in the south-central portion of the state bordering Texas and Mexico. Although it includes the second largest city of Las Cruces, almost half of the county's residents reside in unincorporated, rural communities. The county has consistently been ranked as the fifth poorest Metropolitan Statistical area in the nation, with approximately 39 percent of its children living in poverty.

Prior to the grant, strong community collaboration was already in place, with over twenty family advocate groups, providers, and other public agencies, including education, juvenile justice, and child welfare already working together. When the Federal grant was awarded, a non-profit corporation was formed and a small staff hired. The original concept was that all services, including case management, would be purchased from the member providers. Grant funds were to be used to develop additional services to fill gaps in the local system of care with special attention to be placed on the expansion of the case management infrastructure.

During the first year of the grant it was decided that the *Dona Ana County Child and Adolescent Collaborative* would become the case management entity because it was independent of other services and would not have the proprietary interests that other providers might possess. Case managers coordinated the development of Individualized Service Plans with families and interagency teams. Services identified during the process were brokered from community providers if not available through informal resources or other funding streams.

As a new organization, the *Dona Ana County Child and Adolescent Collaborative* experienced some of the growing pains that any business does in its infancy. The policies and

procedures that were implemented were the first in the community to reflect basic managed care philosophies. Providers initially complained about requirements for service authorization, and some did not think that *Dona Ana County Child and Adolescent Collaborative* should be a "payer of last resort." Also, there were early struggles as accounting and other management systems were developed. For the most part, participating providers and agencies adjusted to the new system of care, but some relationships suffered under the stress of the changing environment.

While the Dona Ana County project was in its infancy, New Mexico was developing a plan to implement a statewide managed care system. Families, advocates, providers, and state agencies worked together to develop this effort. A separate planning group, including *Dona Ana County Child and Adolescent Collaborative*, was established at the state level to develop the plan for a behavioral health system which was originally intended to operate as a carve-out function, quasi-independent of the physical health care system. At the same time, in Dona Ana County, the local interagency council that had been the foundation for the grant was developing a community plan for implementing managed care. The *Dona Ana County Child and Adolescent Collaborative* administration wrote a proposal to the State Department of Children, Youth and Families seeking to become a pilot managed care project, as was intended in the original federal grant proposal. A small group of local community providers became concerned about the potential decrease in funding that might be associated with the move to managed care. They formed a separate organization intended to function as a competitive contractor when the State sought bids for services.

The community providers and advocates, who were not invited to participate in this new initiative, including the *Dona Ana County Child and Adolescent Collaborative*, formed a separate alliance. The philosophies that are fundamental to systems of care became the cornerstones of the new organization, which was incorporated as Olympia Health Management Alliance. The original intention was that Olympia would also focus on developing the capacity to function as a network contractor in the southern portion of New Mexico when managed care became a reality. At that time, most people assumed that implementation of managed care was 18 to 24 months away. Network development was the primary focus, and soon other like-minded groups throughout the state asked to become a part of Olympia because of the systems of care values it represented.

A new governor of New Mexico introduced a different managed care plan known as *SALUD!* The original planning process was set aside. Based on the new administration's concern with the rapidly increasing Medicaid budget, *SALUD!* was developed and implemented in less than 12 months. It provides health services to Medicaid recipients through three managed care organizations under contract with the State. The three managed care organizations are required to sub-contract with a nationally recognized behavioral health organization to provide the behavioral health benefit. These managed care organizations contract with provider organizations and/or individual providers

under whatever arrangements they choose but are not required to include all existing providers in a community.

The rapid implementation of *SALUD!* created several challenges for the Dona Ana project. Since *SALUD!* operates on the principle of "medical necessity," behavioral health organizations and their sub-contractors are reluctant to provide any services that might reflect "social issues." The *Dona Ana County Child and Adolescent Collaborative*'s role as a children's case management entity had provided many families with the knowledge and confidence to function in a fee-for-service environment which allowed consumers to choose their services and providers within the scope of their Individualized Service Plan. Under the new arrangement, the role of case management and access to a wide array of traditional and non-traditional services became more limited.

Change is never accomplished without difficulty. The *Dona Ana County Child and Adolescent Collaborative* and Olympia had to make critical decisions to survive in the new environment. First, the two corporations merged into a single non-profit organization. This allowed the statewide network to benefit from the infrastructure that had developed under the local community's grant. The local organization benefits because it is clear that other State funding streams will soon move towards a managed care focus and contract with regional or statewide alliances rather than with individual providers.

Second, the local organization is expanding its own capacity to provide services. Olympia received State designation as a Children's Community Mental Health Center and is developing services in addition to case management including behavioral management and home-based services. The local *SALUD!* sub-contractor has tentatively agreed to pay for these services. This will provide revenue to support the system of care when the Federal grant ends. A limited amount of intensive case management can be incorporated in Individualized Service Plans, although the behavioral health organizations and regional coordinators have not yet agreed to pay for it as a separate service. Olympia is still looking to demonstrate the value of this service and hopes it will eventually be accepted as a necessary service. In addition to clinical services, Olympia is continuing to develop management information systems, accounting and other managerial capacities that can be offered to other providers to help them meet the reporting and monitoring requirements for managed care.

Relationships with other public agencies such as juvenile justice and child welfare have been strengthened, as everyone adjusts to the new environment. Collaborative efforts that incorporate multiple funding streams have actually increased. Managed care has also brought a statewide focus on outcomes. Olympia is working to obtain national accreditation as a statewide provider network, which will assist each member of the alliance in improving service delivery.

The challenges in combining the values of systems of care with the need to contain costs require participants to be more creative. Diverse sources of revenue are necessary. Providers must demonstrate the effectiveness of their services. Outcome and cost data must be available. Olympia will continue to demonstrate to policy makers that family-centered, wraparound services are critical to obtaining positive outcomes, containing costs, and managing care.

Cultural Competence and Sustainability:
An Interview
K'e Project, New Mexico
Cecilia Belone, Executive Director

The *K'e Project*, working under the auspices of the Children and Families Advocacy Corporation, is located in Arizona, New Mexico and Utah. The project is a community-based system of care that serves the Navajo Nation and offers services in six offices.

K'e, a complex and intricate worldview that runs throughout Navajo culture and life, assumes that family, clan and kinship is central to the well-being of individuals and society. In a broad sense, K'e supports the reverence for all things in the universe, for balance and harmony. At a more specific level, K'e becomes the central process of healing as a child's identity is defined, preserved and protected through family relationships. The K'e philosophy is at the heart of the project and envelopes the services it offers families and children.

The *K'e Project* began receiving Center for Mental Health Services funding in late 1994. Several members of the Navajo Community Advocacy Committee - an umbrella organization linking Navajo Nation, federal and non-profit groups - initiated the grant application process. The committee saw this as an opportunity to expand services to children and their families on the Navajo Nation and to reintroduce Navajo traditions and understandings of the health care into Navajo mental health services.

The Children and Families Advocacy Corporation/*K'e Project* is governed by a ten-member Board of Directors, seven of whom are parents or consumers of the *K'e Project*. The project offices are located in Chinle, Dilkon, Fort Defiance (Arizona) and in Crownpoint, Tohatchi and Shiprock (New Mexico). Five to six staff work in each office. In addition to being a rural population, the Navajo Nation is heterogeneous, experiencing differences in religion, history and culture among the people.

The *K'e Project* relies primarily on Navajo concepts of health and well being in its delivery of services to children and families. Navajo approaches to children's health and well being underscore the family as being central to the mental health of children.

LESSONS LEARNED

When interviewed about the lessons that have been learned from working on this project, Ms. Cecilia Belone, Executive Director of the *K'e Project*, indicated there were two primary lessons.

The first lesson relates to the large topic of cultural competency. "We learned how significantly difficult it is trying to implement a Center for Mental Health Services program from a Navajo perspective or a Navajo way of life," Ms. Belone said. "We're trying to hang on to cultural and traditional teachings and practices. As a people, we have high expectations of self. We should have no questions about this; there should be no question about this: to know who we are, where we come from, our responsibilities as male and female."

The central theme for the Navajo lifestyle is the concept of K'e. It's the place the whole family concept comes from. K'e is a universal value system and includes, wisdom, balance, harmony, sharing, caring. All these human values are experienced through clanship, kinship and extended family. The whole of Navajo life is built around family.

"With our people, most of them retain these values but don't necessarily practice them. I was exposed to them. My mother was removed from home and taken to Christian school. She took those (Christian) values and encouraged me to do the same. Many Navajo people and other Native Americans feel denied their traditional ways of life. Now we're having to take this extra effort of relearning," Ms. Belone said.

"That the Navajo way is a holistic approach now being revisited by wraparound and Child, Adolescent Service Systems Program principles is very confusing," Ms. Belone said. The old ways of caring for others and restoring and maintaining harmony that American Indians have been socialized away from were much like some of the general aspects of the wraparound and Child, Adolescent Service Systems Program processes that this project encourages. "We are trying to re-teach the Navajo way, but we are using the mainstream (dominant) society's methods in many cases. Those ways meet sometimes, somewhere in the middle."

"We were not aware of how much time, energy and effort that would take. No matter how much we believe in K'e, our assumptions (have come to be tied) to the medical model. There's the constant reeducation of our people. The agencies we deal with - Bureau of Indian Affairs and Indian Health Service — reinforce federal paternalism. So it's been a struggle with the two cultures. When you have people already struggling with their identity and you're trying to reorient them to the old way and be professional and appropriately distant, it takes a lot of extra effort. It's demanding," Ms. Belone said.

For her and many single women, as well as for the many families headed by women that the project serves, there are barriers of male and female to overcome, according to Ms. Belone. Based on the philosophy of the hogan, women are the caretakers of the home and the children, and men are the leaders and the breadwinners. "This kind of cultural knowledge takes reorientation and reeducation. You have to go slow. As staff, we have to conduct ourselves with patience and propriety or it's not K'e we're practicing," she said.

"You know how I always say one of the cultures is backwards. We say it's the white culture. But on this project, it's as if the Navajo culture is backward. It's frustrating. We have to take the extra step, make the extra effort to accommodate," Ms. Belone stated.

Ms Belone speculated what it would be like for all the services grantees to accommodate the expectations of another culture's mindset in that culture's language as they provide mental health services to children and their families within their own culture. "Their [Center for Mental Health Services] expectations reflect their way of life. They do not reflect our way of life. I have to ask myself, is it benefiting me, is it benefiting our children and families? There is a lot about Medicaid we don't agree with and may not do. [Center for Mental Health Services] has been flexible, but we've been trying to provide education. They're not trying to take steps to understand how this is for us or do anything about it. There are a lot of literal interpretations," she said. The literal interpretations get in the way of providing culturally competent mental health services to her people and perhaps, they speculated, to many other American Indians, particularly those residing in rural areas.

"Let's take a family. From referral to intake you have seven days. If your family and staff only spoke English, you'd have a pretty easy time maybe," Ms. Belone suggested. From the seventh day, you have 21 days to do an assessment, she said. The number of days allowed is dictated by the Center for Mental Health Services and Medicaid.

In Navajo Nation, families often live long distances away from services and can be difficult to reach during harsh weather. It's rural and isolated. "First, the instrument has to be translated. You're lucky if you find the family on the first visit. It's rural. Even if the family is home, you can't just bring out the form on the first visit. You have to develop thrust so maybe you can bring it out on the second visit. At the same time, then, you have to give full information back," said Ms. Belone.

There's a western assessment, a traditional assessment, an individual service plan (comprehensive service plan) and a treatment plan. Each step of the way, it's done in two languages. Double the work takes double the time. It would be better if grants for projects where the work proceeds in two languages could be awarded for a longer period of time to accommodate that extra time and effort that working in two languages and two very different cultures requires. That accommodation would allow

project staff working in their native tongue and reporting in a second language an additional edge toward sustainability, Ms. Belone said.

That brought her to the second lesson — about sustainability — that Ms. Belone, who has held the position of Executive Director for less than one year, has learned. To enter a project such as this is to face many unexpected things, things that cannot be foreseen she said, so unwavering focus on sustainability is critical right from the start. "Do not write your proposal and policies just for a Center for Mental Health Services grant. Write it for whatever will sustain you. You need to know that from the beginning. For us it's New Mexico Children, Youth and Family Department and Medicaid. You need to know that so you can comply with the regulations like Medicaid's. You need to know that so you can comply with regulations like Medicaid's. You have to know what those things are to sustain your project."

North Carolina System of Care: Parents in Residence Model

PEN-PAL & North Carolina FACES Projects

Martha Kaufman, Project Director

In February of 1994, North Carolina's Pitt and Edgecombe-Nash Public Academic Liaison (*PEN-PAL*) *Project* received a grant from the Center for Mental Health Services, through the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services Child and Family Services Section. The project's primary objective is to establish a comprehensive community-based system of care for school-age children and adolescents with serious emotional disturbance who are at risk for or placed out of the home, and their families. Full and active partnership with family members and among all child-serving agencies in all aspects of project implementation, management, and evaluation is a primary goal for the project. Services have the goal of maintaining children in their homes, providing care in the least restrictive setting, discouraging service dependence, encouraging children and families to become involved in naturally occurring community supports, and optimizing the value of services provided. The project is based on the belief that there are three elements important to the development and management of a high quality community-based, interagency/community system of care: 1) a shared philosophy among agencies, families, and community; 2) a multiagency/community infrastructure for service planning and delivery; and 3) pre-service and inservice training and technical assistance for providers, family members, university faculty, students, and other community stakeholders to promote learning and application of the values, attitudes and skills necessary for implementation of a system of care.

In recognition of the important role of academic training programs charged with preparing professionals to work in the public sector, the need for state of the art training approaches, and the desire to build a broad community-inclusive effort to implement a system of care, faculty from East Carolina University (part of the University of North Carolina System) became partners with the *PEN-PAL Project*. Faculty from six of the university's schools and departments participated, including the School of Arts and Sciences, Department of Psychology; the School of Education; the School of Human Environmental Sciences, Marriage and Family Therapy Program; the School of Medicine, Child and Adolescent Psychiatry; the School of Nursing; and the School of Social Work. These faculty formed the East Carolina University Social Sciences Training Consortium and worked interactively with project staff and community stakeholders, to develop state of the art curricula, and provide training and consultation to service providers, family members, community representatives, and university graduate students. Consortium members served as members of the project management structure, and attended national conferences regarding system of care development, as did members of interagency staff and family teams. They also worked with staff and families in

service delivery in the emerging service system. As faculty learned about new system and service approaches, their goal was to translate these learnings into curricula that incorporate systems of care philosophy and techniques. The curricula would enhance inservice training for staff of all agencies involved with children with serious emotional disturbance and their families. The curricula would also be used in academic settings, with the goal of producing graduates with training that is relevant to the needs of the evolving service system. Original project goals established to address the role of this academic partnership include:

- to use the training and supervisory capacity of East Carolina University faculty to develop curricula for pre-service and inservice training in Systems of Care practice;

- to involve the project management structure, families and providers in formulating the content of the curricula;

- to train providers in the practice of Systems of Care service delivery; and

- to use material to assist other sites in program development.

PROJECT STRUCTURE

The *PEN-PAL Project* utilizes a three-tiered interactive service and management structure. At the core of the system are Individual Service Teams. These teams are built around each child and family upon entry into the project, and are comprised of the immediate and extended family, the participating agency, community and neighborhood representatives involved in the everyday life of the child and family. Second, Project Management Committees in each catchment area drive system implementation and evaluation while supporting the work of Individual Service Teams through coordination of local policy and procedures, integration of local funding streams, and problem resolution. The Committees are comprised of family members, child-serving agency management and providers, East Carolina University faculty and staff, and other community representatives. Third, a State Oversight Committee, comprised of key representatives from family advocacy groups, state and local child-serving agencies, and East Carolina University faculty, provides state level policy integration and coordination, guidance, and assistance to the local Project Management Committees to ensure the success of Individual Service Teams. Family members, family advocates, and support organizations participate as full and active partners in all levels of the service and management structure.

To ensure family voice and presence in system of care training, technical assistance development, and delivery, universities participating in the North Carolina Public Academic Liaison (PAL) initiative will contract with Family Support and Advocacy Organizations affiliated with local system of care sites. Adherence to Child Adolescent Service System Program values and principles and to requirements of the Pitt-Edgecombe-Nash Public-Academic-Liaison and North Carolina

Families and Communities Equal Success (North Carolina FACES) grants requires that parents of children with serious emotional and behavioral problems participate as full and active partners in the development, delivery, and evaluation of training curricula for students in graduate and undergraduate classes and for community/agency service providers.

PARENTS IN RESIDENCE MODEL

Background

In 1995, a Parents in Residence pilot project began at East Carolina University through the *PEN-PAL* Resource Center and the Social Sciences Training Consortium. The Resource Center, a partnership between the School of Education and Medicine/Department of Child and Adolescent Psychiatry, provides or coordinates inservice training and technical assistance to promote implementation of the system of care. The Consortium, through a partnership between faculty in the departments of Psychology, Marriage and Family Therapy, Nursing, and Social Work, provides pre-service training for graduate students in their respective fields.

The Parent in Residence pilot began when the parent of a child receiving services through the *PEN-PAL Project* was hired to work in the Resource Center to ensure integration of a family perspective into all training and technical assistance activities. After a year of experience with this initial model, family members and project staff agreed that a shift to a contractual arrangement with the community's emerging independent Family Support and Advocacy organization would better promote an equal partnership between family members, university administration and faculty, state and local project staff. Moreover, the need to identify strategies to sustain independent Family Support and Advocacy organizations in the fourth of a five-year federally funded grant (*PEN-PAL*) became a high priority. With the advent of the newly funded North Carolina FACES grant, family members and project staff have an ideal 'systems laboratory' to promote strong linkages between local Family Support and Advocacy organizations, establish models that respect and strengthen the independence of grass-roots Family Support and Advocacy organizations through contract revenue, and create a norm for Family voice and presence in student and community training.

Preservice Activities

Cross-discipline faculty participating in the North Carolina Public Academic Liaison initiative seek to integrate system of care principles and practices into their respective graduate and undergraduate pre-service curricula by incorporating the study of system of care principles and practices into existing coursework, developing and delivering new cross-disciplinary team-taught courses, and establishing cross-agency/community field-placement for their students. The East

Carolina University, serving as a pilot site, will ensure family voice and presence by contracting with the emerging independent family organization (With Every Child and Adult Reaching Success - *WE CARE*) representing Pitt, Edgecombe and Nash counties. *WE CARE* provides:

- training and support for family members interested in providing assistance in curriculum development, review, and/or delivery;

- family representatives to develop and review curriculum;

- family representatives (parents and children) to team teach with faculty and agency providers; and

- a field-placement opportunity for students.

East Carolina University contracts with *WE CARE*, providing funds and technical assistance for *WE CARE* staff and/or stipends for families who are not paid by the family organization (family volunteers) to work with the faculty and students as Parents in Residence for a semester. A scope of work negotiated between the university and the family organization details respective responsibilities, expectations, and remuneration. This arrangement allows numerous family members, and often their children, to participate in preparation and instruction of university courses, while exposing scores of future service providers to the first hand experiences and perspective of family members.

Inservice Activities

All agency service providers, family members, and family advocates, along with university faculty representing various disciplines participating in the North Carolina system of care and PAL initiative, receive inservice training on system of care principles and practice through the *PEN-PAL* and North Carolina FACES Projects. Train-the-trainer sessions are also provided to participants interested in being Peer Trainers. Peer Trainer teams work within and across system of care sites, in cross-agency/family teams that model and instruct others in system of care principles and practice. The East Carolina University *PEN-PAL* Resource Center has utilized Peer Trainer teams to assist in local and statewide training events. Similar to the arrangement that ensures Family voice and presence in pre-service training, a contract between the Resource Center and *WE CARE* provides funds and technical assistance for *WE CARE* staff and/or stipends for families who are not paid by the family organization (family volunteers) to work as Parents in Residence on Peer Trainer teams. A Scope of Work negotiated between the university and the family organization details respective responsibilities, expectations, and remuneration. This arrangement allows family members to participate as colleagues in the training development and delivery process, and models family-provider collaboration through the delivery of inservice training.

Application

The Parents in Residence model is evolving as local family support and advocacy groups emerge through the *PEN-PAL* and North Carolina FACES Projects. State and local staff, along with university faculty, will continue to field test the model, adapting it to reflect the strengths and needs of various communities. Although variations in the model will and should occur, the precedent for family inclusion in training and technical assistance at universities in North Carolina has been established and will undoubtedly be strengthened as implementation of the system of care moves forward across the state.

Individualized Services

North Dakota Partnerships Project
Paul Ronningen, Administrator of Children's Mental Health

The North Dakota Partnerships Project is a five-year grant funded by the Center for Mental Health Services in 1994. This project consists of three of the eight human service regions in the State of North Dakota serving approximately one half of the 170,000 youth in the state who are under age eighteen. The project was initiated to demonstrate the effectiveness of home and community-based care for youth with serious emotional disturbance and their families. In order to accomplish this task, these regions brought together the child serving agencies (juvenile justice, education, social services, mental health and Medicaid) and families in their area to design and deliver services that would enable children to receive services in their community. If the demonstration was successful, children would not be required to leave their families for hospital or residential care in communities that could be hundreds of miles away.

The development of a system of care for youth with serious emotional disturbance and their families involves a multitude of complex issues ranging from developing a full array of services, building family support networks, blending of various funding streams, data collection and analysis, technical assistance and training, etc. However, these challenges can be significantly more difficult if your system of care has not taken sufficient time to clarify the roles that the various child serving agencies play in providing services to a single family.

The principles of the Comprehensive Community Mental Health Services for Children and Their Families program give agencies and families a template for the construction and delivery of services. This template however does not resolve the day to day issues, which arise when the historical roles of agencies appear to clash with the principles of the project. Without adequate training for each of the partner agencies and families to fully understand those agency cultures and the strengths-based model of individualized service plans, unresolved issues will impede the progress in implementing the system of care. Trust and respect for each other can easily be replaced with blame and skepticism if training and technical assistance around these issues receives inadequate attention.

Following is a brief description of roles of the Federation of Families and the agencies that participate in providing services in the system of care in Region VII:

Burleigh County Social Services is the public child welfare agency for both Burleigh and Morton counties. Federal and state law charges the agency with family preservation with a primary emphasis on the health and safety of children. Social services works closely with the juvenile court in determining deprivation of children and adhering to the federal and state statutes and regulations

governing the treatment of children and their families for whom the federal government funds services. This means children should be placed in the least restrictive placement, which, if possible, is the child's home and/or community. Pursuant to state law, Burleigh County Social Service receives custody of deprived children from the Juvenile Court.

The *West Central Human Service Center* is a publicly funded community mental health center and one of eight regional human service centers in North Dakota. Part of the Department of Human Services, the Center serves a ten county area. Its mission is to provide an array of quality human services, which support and enhance the quality of life of people in the region. The Center is also an umbrella agency and provides the following services: psychological, psychiatric, addiction, acute mental health, case management, developmental disability, vocational rehabilitation, aging services and supervision of county social services.

The mission of the *North Dakota Division of Juvenile Services* is to provide a continuum of services to delinquent and unruly youth in North Dakota and to protect society from those youth who are of danger to themselves and others. This is accomplished through the development of an individualized treatment and rehabilitation plan for each youth and through the provision of an array of services by a dedicated staff who ensure the youth receives these services in the least restrictive environment. When a youth is committed to the custody of the Division of Juvenile Services, a case manager is assigned to work with the child and his/her family for the duration of the court-ordered commitment. That case manager is entrusted with the responsibility of being a legal custodian for the youth.

LESSONS LEARNED

Following is a description of the issues confronted by mental health, child welfare, juvenile justice and families as the various roles of agencies and families were handled during the implementation of our system of care.

Comprehensive Training Required

Cross training across the agencies and families in the North Dakota Partnerships Project has been an effective way of opening communication channels for the participants in multi-agency systems of care. Each agency representative and the family organization require a comprehensive knowledge of the goals of the system of care with a working knowledge of the development and implementation of a strengths-based care plan. In addition, training members in the team process is also very important for effective and efficient service delivery. Team members need to have a clear vision of the teaming process and also understand the various roles of the other members. Foremost,

families should have voice, access and ownership in this collaborative process; i.e. family members should be full team members.

In addition, it is important to understand the role of the custodial agency (county social service or the Division of Juvenile Services) and the requirements placed on that agency by the Juvenile Court. Custodial agencies do not have the power to change court orders. These agencies can, however, enlist the aid of the Juvenile Court to revise the order when the care coordination team is able to develop a care plan that ensures the safety of the child, family and community.

Communication and Cultural Issues

Evaluations are a strong component of the North Dakota Partnerships Project. However, in order to understand the strength and competency of each care coordination team, an evaluation process should be developed. For example ask: "Is the process effective? Why and what could be improved? Are members able to effectively communicate their ideas and needs?"

For the wraparound process to truly work, people need to take risks at the team table. This means that concerns, skepticism, and fears must be communicated clearly. In North Dakota, our culture appears to make their need for overt risk taking difficult. This culture is often referred to as "North Dakota Nice." To the untrained eye, it might appear that team members are agreeing, but after meeting adjournment, true attitudes are vocalized in prospective corners. We have gotten better at taking risks at the team table, but this cultural norm continues to be an ongoing challenge to the teaming process.

Developing the System of Care is an Ongoing Process

One of the biggest lessons learned is that developing and refining the system of care is an ongoing process; thus, communities who engage in this work should make a long term commitment to the work. With ongoing dialogue, parents and professionals will feel they have voice, access and ownership in the system of care that is built together. Planners and other participants should never assume that a particular message has been finally communicated.

IMPLICATION FOR OTHER SITES

The system of care is ever evolving. New partners and families come into the system of care on a daily basis requiring ongoing training on roles, responsibilities, values and principles. This is a

process that needs continual attention through the implementation of an effective orientation process, honest discussion at care coordination and policy meetings. The culture of the project site, of the agencies and the family organization should also be recognized and addressed. Without open dialogue, there are "tremendous opportunities to be misunderstood."

With this in mind, other sites should consider the following:

- Create extensive opportunities to conduct cross agency training with full family participation. Understanding of the system of care will enable each of the partners to be more effective in delivering care. Regardless of an agency's "official" position of embracing service delivery approaches such as wraparound, the beliefs of individuals at the table should drive the outcomes.

- Having families at the service-planning table, presented with information, options and risk, can support relationships building, barrier identification and clarification of communication. Implementation of these processes can result in better outcomes for families.

F.R.I.E.N.D.S. Mobile Community Support Service: Building Bridges Between Parents and Schools

Bronx, New York

Katherine Gory Levine, Program Manager,
Mobile Community Support Service

The Mott Haven *Families Reaching In Ever New Directions (F.R.I.E.N.D.S.)* Initiative is located in the South Bronx of New York City. The two square miles of this urban community are populated by approximately 85,000 people, 45 percent of whom are under the age of 21. The community is very diverse with multiple ethnic groups within the 67 percent Hispanic and 32 percent African American populations. Although Mott Haven experiences many of the stresses that are frequently found in large urban communities, its members are very concerned about the future of their children. Over a number of years, several members of the community participated in the design of a system of care for children and their families. In 1994, the State of New York was awarded a grant by the Center for Mental Health Services on behalf of the Mott Haven neighborhood. Upon receipt of this award, a series of conversations occurred with family members, community representatives, service providers, and city and state officials to verify that the proposed services addressed the community's needs.

Initially, adjustments to the implementation plan developed by the State were made to reflect the needs of the community. Families immediately identified the need for a "Mobile Community Support Service" as a priority. Several family and community members noted:

> *"Crisis intervention is too late. If we are in crisis we know where to go for help. What we need is help before the crisis. We need help when things are starting to get tough or we have questions about what they are doing or when our children begin to have problems at school."*

These comments made it clear that *F.R.I.E.N.D.S.* needed a visible responsive presence in the community, particularly in schools, with the capacity to provide information, proactive intervention and support, as well as crisis intervention.

The service delivery plan was developed and shared through a competitive bid process. A Request for Proposals process was opened to community-based organizations in the Bronx, NY. A Planning Board, comprised of 51 percent family members from the community, selected the Visiting Nurse Service of New York as the Mobile Community Support Service provider. Their proposal successfully melded the concepts of a mobile crisis intervention team and a home-based crisis

intervention service into a flexible model that addressed the community's desire for consultation and information as well as intervention.

The Mobile Community Support Service has staff composed of a psychiatrist, three social workers, a nurse, three counselors, two parent advocates, and two case aides in addition to the program coordinator. The service has the capacity to provide 4-6 weeks of intensive in-home intervention assessment; direct service to children at risk of removal from home, school, or community: consultation regarding children at risk; and training regarding the needs of children experiencing serious emotional disturbances with a focus on strength-based assessments.

The plan to make the Mobile Community Support Service responsive to the community began with outreach work to eight of the neighborhood schools. Initial visits to these schools served a number of purposes including outreach, discussion of how referrals could be made for children in need, presentation of the *F.R.I.E.N.D.S.* Mobile Community Support Service menu of services, and discussion of the school's needs. It became clear almost immediately that school personnel wanted:

- to give children the opportunity to succeed in school;

- to use the Mobile Community Support Team as a crisis team whenever a child needed hospitalization and/or removal from the school;

- access to quick psychiatric evaluation for all the children with challenging mental health problems;

- relief from having to make referrals to the local child welfare office for children they suspected were being neglected or abused; and

- help with engaging parents whose children had mental health problems.

Conversations with the family members revealed similarities and differences in the needs they identified. Parents wanted:

- to give children the opportunity to succeed in school;

- to be informed in a timely and respectful manner when their children were having trouble; and

- help in dealing with school personnel.

At the end of the 1995-1996 school year, a number of schools had agreed to ongoing contacts with the Mobile Community Support Service, which included making referrals and receiving in-service training for their teachers. As the 1996-1997 school year opened, outreach efforts with the other neighborhood schools began in earnest. Many different doors were used. The Parent Volunteer

Associations were instrumental in linking schools with the *F.R.I.E.N.D.S. Project*, the Mobile Community Support Service received referrals through these groups, helped them establish parent support groups, and provided Anger Management and Aroma Therapy Workshops for the parents and teachers as part of a year-end Appreciation Day activity.

In one school, the school psychologist invited the Mobile Community Support Service staff to meet with school personnel to discuss their concerns about particular children. After several months of providing consultation and a few successful referrals to the system of care, the Mobile Community Support Service team was asked to help with a second grade class considered "out of control." Children in this class were repeatedly sent to the office for behavior problems and the teacher was threatening to quit. The Mobile Community Support Service team began to visit the classroom as "Feeling Detectives." The children were told that these "detectives" were going to teach them about feelings, how feelings come and go and how to deal with them. The purpose was twofold: to observe the class and to provide the children with better skills to read and respond to each other's feelings, and thereby reduce their acting out. By the end of three sessions, the team had observed that several of the children had serious emotional disturbance and needed more attention.

One child was actively hallucinating and could not be controlled. His behaviors included shutting himself in a closet for some quiet time, washing all the black boards and other furniture in the room, darting out of his chair, and antagonizing the other children by being unable to observe appropriate boundaries. Two other children were clearly hyperactive and unable to attend to instructions or remain seated for more then 40 to 50 seconds at a time. Another child was selectively mute 98 percent of the time. She would not talk to any adults even to the point of refusing to respond to questions. When circumstances demanded she communicate, she did so through one of the other children.

The observations of the Mobile Community Support Service helped the school psychologist and the teacher see that the mix of children in the class room was the problem: even with three or four adults in the classroom trying to help, chaos was still always just a moment away. Families of the identified students were invited to meet with the school psychologist and the Mobile Community Support Service team, and were referred for help.

Another school requested training for teachers around issues of dealing with children with serious emotional disturbance. This school had become familiar with the *F.R.I.E.N.D.S.* services through experience with individual students. Two types of training were instituted. The first was a traditional workshop focused on managing feelings; the second involved running a demonstration course on managing feelings in one of the special education classes. The children and staff were taught together. The material covered in both of these consultations included awareness of feelings, how to spot the start of a negative feeling, when and how to take a time-out, how to calm the body

when a feeling hypes it up, and how to act appropriately on all feelings. The workshop consisted of two-hour sessions once a week for three weeks; the class consisted of a 40-minute period every other week for ten weeks. The school, the teachers and the children considered both of these consultations quite successful. One measure of the success is that several other schools requested similar services.

The Mobile Community Support Service is now firmly established as a presence in all the neighborhood schools in Mott Haven. Some schools call *F.R.I.E.N.D.S.* primarily for referrals to traditional mental health services, but many schools now think of *F.R.I.E.N.D.S.* and the Mobile Community Support Service as an ally in serving children at risk of removal. There is a strong sense of partners coming together to plan on a broader basis with school administration, teachers and parents.

One of the most obvious lessons learned through this process is how to be better partners with schools on their terms. This knowledge has allowed us to achieve many of our goals toward the establishment of a system of care. We also found that families and schools both want their students to do well, but both can use assistance in communicating with each other and other systems. Suggestions for developing partnerships with schools include:

(1) Start with whoever invites you into the school. In one school that might be a principal, in another a parent association, in yet another a teacher.

(2) See challenging situations as an opportunity to demonstrate the value of your service. One intervention that effectively meets the needs of the child, the parent, and the school opens many doors.

(3) Use a strengths-based needs assessment throughout all school contacts. Schools and parents often seem at odds, but both want the same for the children. Seeing the strengths of each builds important bridges.

(4) Never say "no" to a service request.

(5) Meet the initial invitee's needs. If a service request doesn't seem to fit your program criteria, say, "Let's see how we can do something together that will meet your needs and our criteria." Figure out how to offer something that will satisfy.

(6) Help school personnel see the strengths of the families by being a good role model.

(7) Think quality. Offer services and products that help.

(8) Stay humble. See all gains as a part of the partnership process. One alone can do little; many joined together find solutions.

(9) Admit mistakes.

(10) Evaluate, evaluate, evaluate. Ask everyone over and over again for feedback. Is this

helping? How is this helping? What would help more?

(11) Appreciate, appreciate, appreciate. Write thank-you notes. Sponsor appreciation workshops.

School staff come and go, administrations change, needs change and the consultations go on. The learning goes on as each school year begins its cycle again. In Mott Haven, the use of a strength-based, individualized care approach to schools is proving to be just as effective as it does when it is offered to families.

Ohio's System of Care[1]

A Year in the Life of a Juvenile Court Liaison

Southern Consortium
Southeastern Ohio

Benjamin M. Ogles, Ohio University and Southern Consortium for Children; Amy McGlone, Shawnee Mental Health Center; Joyce Lynd, Lawrence County Juvenile Court

One of the critical elements necessary for the construction of a comprehensive system of care for children and adolescents is the need to integrate and coordinate services provided by multiple child-serving agencies (e.g., mental health, child welfare, juvenile justice, and education). Many people point to the Children's Defense Fund publication of Unclaimed Children (Knitzer, 1982) as a key turning point in policy perspectives and system development for children who have mental health service needs. Unclaimed Children highlighted the fact that many children with mental health needs were not adequately served because of the lack of coordination among child serving agencies and the limited range of available services. Perhaps the major tenet for the construction of a comprehensive system of care is that mental health services should be coordinated with a network of other child and family services (e.g., child welfare, juvenile justice, and education). To address this situation, the construction of a comprehensive system of care was recommended.

The System of Care Initiative in rural southeastern Ohio was funded by the Center for Mental Health Services with service system integration as one of several key goals. The initiative was created in response to the growing interest in providing a comprehensive array of mental health services within a system of care and to make further attempts at involving families at all levels (policy, program evaluation, and service planning), as well as increasing cross-system integration and coordination. Within the site, coordination with the juvenile justice system was improved by assigning mental health providers to work in the juvenile court office. This work describes the experiences of one juvenile court liaison, the children and families served during one fiscal year, and the outcome of those services. Data from these efforts suggest that improved coordination between the juvenile justice and mental health systems prevented unneeded hearings and facilitated access to needed services.

Three mental health professionals known as "Liaisons" (employed by the local community mental health center), were assigned to work within the juvenile court offices of three contiguous counties. Each of

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[1]Ohio's federal grant support system of care in Southeastern and Starks Counties, both of which are highlighted here.

the Liaisons had previous work experience as case managers within the community mental health system. Liaisons has offices at the community mental health center, but used the bulk of their time in the juvenile court offices. Most of their work was done in partnership with probation officers and it focused on the identification of children who might benefit from mental health services. The goal was to divert cases from adjudication when appropriate, help parents and children access other services when requested, and handle emergent situations.

Youth and their families were referred to the Liaison when emotional or behavioral problems were thought to contribute to their court involvement or when the possibility of diversion from court proceedings seemed likely. A total of 115 male and 80 female youth (average age 14 years) were referred to the Liaison while involved with the juvenile court during the 1996-97 Fiscal year. This represents approximately 20 percent of all youth referred to the court during the year. Probation officers and other court personnel were encouraged to make referrals to the Liaison for screening rather than deciding about the potential benefit of the referral themselves.

The Liaisons played a very important coordination role in the service delivery process; they connected families to needed services across the system of care. When families were referred for additional mental health services, the Liaison followed up with the case to aid in access to services and to prevent probation violations for non-participation. Youth who were involved with the court as a result of status offenses were referred to the Liaison more frequently than youth that were involved with the court as a result of delinquency. The most frequent offense was ungovernable behavior with truancy as the second most frequent offense. For many of these cases, families were connected with services despite the need for adjudication.

More than half of the youth (117 of 195 or 60 percent) was on probation for previous offenses at the time of their referral to the Liaison. For these youth, as well as those involved with the court as a result of more serious delinquent behaviors, diversion from adjudication was not possible. As might be expected, at the time of their referral youth that were on probation were significantly older than youth that were not on probation. However, youth that were involved with the court for delinquent behaviors were not significantly older than youth that were involved with the court for unruly behaviors.

Of the 195 referrals to the system of care, 67 (34 percent) were diverted from adjudication - the cases were not filed. Youth who were on probation and charged with delinquent behaviors were much less likely to be diverted from adjudication than youth that were not on probation and charged with unruly offenses. Finally, an examination of the past three annual years of cases filed suggests that there were significantly fewer unruly cases filed in the most recent year. Although the work of the Liaison cannot be definitively identified as the sole cause of this decrease, the number of diversions for youth referred as a result of unruly behavior suggests that the Liaison certainly contributed to the decrease in the number of cases filed.

As has been clearly demonstrated, use of a juvenile court Liaison substantially reduced the number of unruly cases filed. Future efforts in the site may seek to target children whose involvement in the juvenile justice system is more complex, to ascertain other potential avenues of service, and to evaluate the effectiveness of services that accompany adjudication. The coordination of service delivery between the mental health and juvenile justice system demonstrated by this project supports the supposition that implementation of system of care principles can result in improved outcomes for children who have serious emotional disturbance and their families.

A System of Care for Children and Families

Stark County, Ohio
Carol Lichtenwalter, Project Director

A system of care is a cross-system, coordinated network of services and supports organized for the purpose of addressing the complex and changing needs of children and families. The system of care includes organizational and administrative structures, formal and informal processes, and formal and informal resources. Thus, it is possible to say that a "system of care" exists to a greater or lesser degree in every community. The extent to which a community assumes the responsibility for "system of care" development is typically evidenced through a viable community organization and governance structure, increased emphasis on parent family involvement, and the creation of flexible funding resources. In communities where this ownership occurs, there is real and felt presence of both public and private systems response, ensuring that families receive needed services and supports.

The true test of any system of care, however, is the experience of any given child and family with a specific need or set of needs. That is, the answer to the question, "Can the members of this family get what they need, when they need it, in a manner that is acceptable to them, and appropriate to the strengths and challenges they bring to the situation?" It is the true test.

In order to understand the experience with System of Care development, it is important to understand the community in which these efforts exist. Stark County is located in the Northeast quadrant of Ohio. The largest growth in population seems to be centered in working poor people. The total population is 367,585, 92 percent of whom are white. Stark County is the seventh largest county in Ohio. Its major cities include Canton, Massillon and Alliance. Canton serves as the urban hub for the county, with approximately half of the county's population residing in the Canton/North Canton area. The other two population centers, Alliance and Massillon, are located some distance from Canton. Due to a history of inadequate transportation services between the three areas, social service agencies have traditionally provided some sort of service in all three areas. Except for the urban hub, most of the

population is characterized as either suburban or rural. Poverty is on the rise in this area. Since the early 1980's it has continued to change from a manufacturing to a more service-based economy.

In Stark County, system and community representatives are serious about coming together to do business. There is a clear agenda and a clear procedure for accomplishing policy and administrative level tasks, which have direct benefits for children and families. The Stark County Family Council serves as the coordinating hub for System of Care activities. The Family Council is organized in the following ways:

- *The Family Council Board of Trustees.* The Board of Trustees is responsible for system development, resource development, redirection of resources, and policy impact. This role is very clear in the county and also serves as a point of accountability to the community. The Board models the business of doing business by maintaining a publicly held and viewed agenda and maintaining clear records of decisions made through publicly reviewed resolutions. This allows the Board of Trustees to be collectively accountable while building a base of accountability for individual system participants. Membership on the Board of Trustees includes System Executives, parents and at-large community members elected from the general membership. Each member of the Board of Trustees has a clearly spelled out term of office, which is documented in the Family Council by-laws. Additionally, the Board of Trustees' base of authority is articulated in the Ohio Revised Code, which requires that it operate as a public body.

- *ACCORD.* Recognizing that systematizing support for children and families would take more than efforts by the top level executives in the county, Stark County has developed a clear forum for mid-level managers to come together across systems. This group's primary responsibility involves assisting direct service staff through reviewing individual situations of children and families, bending bureaucratic rules, identifying service gaps, and developing new services when trends are recognized. In addition, the ACCORD group manages all out of home care that includes a treatment focus. In managing this resource the ACCORD is responsible for authorizing length of stay as well as expenditures which come from a pooled fund. This group consists of representatives from various systems and agencies as well as parents of children who have received public and private service. This group, the Accord, has a clearly delineated set of responsibilities and roles which include managing lengths of stay in out of home care, reviewing plans developed through a cross system planning process and managing the pooled funds. These responsibilities are articulated through the Board of Trustees who hold public meetings. The ACCORD is responsible for managing pooled funds and reporting to the Board of Trustees on a quarterly basis.

- *Creative Community Options.* This is a cross system service planning process with families which can be accessed and implemented by direct service staff. Far too often, collaborative efforts look really good at the top but have little payoff for direct service staff. The Stark County Family Council has taken care to assure they can build a process which can be implemented across systems under the auspices of the Council as well as outside the parameters of the Council. The Creative Community Options process represents a forum in which direct service providers and families can come together around the needs of the single child and family. Membership changes based on who is most attached to the child or family and the preferences of the family. Meeting frequency is based on family needs. The process is designed to move practice toward a better fit with the driving principles of Stark County efforts. The Council tracks all Creative Community Options meetings to assure that collaborative efforts are continuing to have an impact at the direct service level. Since initiating Creative Community Options across

systems, Stark County has experienced a dramatic reduction in the number of children placed in out of home restrictive care.

■ *Working Councils.* The Family Council also utilizes a series of working councils which assist with completing the business agenda. Those can be ad hoc committees designed to deal with specific tasks or issues, or longer term committees which address specific issues over time. Examples of specialized committees initiated in 1996 included committees on Community Violence, Communications, Cultural Competence, Managed Care, Operations, Young Children, and Employment.

■ *Parent Advisory Council.* The Board of Trustees of the Family Council originally established a permanent arm of the Board, which was the Parent Advisory Council. The Parent Advisory Council advised the Council on all family related issues and was responsible for forming the linkage between the Council and families. The Parent Advisory Council also took on responsibility of communicating information about the Family Council to families within Stark County. Since its inception the Parent Advisory Council has changed. Through efforts of parent participants representing many parent organizations, family members have formed an organization with 501(c) 3 status under the Internal Revenue Service Code. This group is called FACES (Family Advocacy + Community Education = Support) of Stark County. The Family Council also maintains a Parent Department staffed by two full-time Parent Coordinators.

■ *Family Council General Membership.* The Family Council, as the collaborative body for Stark County, is committed to inclusive opportunities for all members of the community. As a result, the Board of Trustees has created a membership structure associated with the Council. At this time, membership totals over 100 people and includes any individual or organization within the community whose personal, professional, or organizational interests are compatible with those of the Council. Individuals request membership status in writing and formally become members within 30 days of such a request. All changes to the by-laws must be ratified by an affirmative majority vote of the General Membership. This open community membership, which is rare in community councils, allows the Family Council to balance a business agenda with the need to be inclusive around guiding principles.

■ *Family Council Staff.* Most Board of Trustees members indicate that, at some point, collaborative efforts will require an investment on the part of participating systems through developing and supporting clear staff roles and responsibilities for the collaborative effort. Council staff includes a Director, which is an executive level position, directly responsible to the Board of Trustees. This position is influential both in terms of Family Council business as well as the business which occurs within existing systems. Other staff positions include a Program Development Specialist, a Benefits/Entitlements Coordinator, a Parent Coordinator, a Minority Outreach Parent Coordinator, a Finance Manager, and administrative support staff. Even though Family Council staff have different areas of expertise, they all use similar approaches in completing their tasks. Each staff person is involved in bringing together groups from different areas of specialty to make collaborative decisions about funding, programming, access, and other related issues.

A review of the Family Council's by-laws makes it very clear that this community infrastructure has several key ingredients which include:

■ *A clear base of authority from which to operate.* The Council was created through a resolution of the County Board of Commissioners in 1993. This clear base of authority allows the component parts of the Council to do business and hold public accountability. The Council is accountable to the community, which is operationalized through membership participation as well as reporting to the County Commissioners.

■ *Clear lines of authority and responsibility.* In building a collaborative infrastructure this community has paid attention to roles and responsibilities. Accountability for daily activities and policy implementation is very clear, with the County Commissioners approving the budget and the County Auditor managing funds. Achieving this clarity is difficult to do with many collaborative structures since they often lack an "up front" plan, but rather grow and develop over time. Anyone in the community who wants to participate in Family Council activities is welcome. More importantly, they also have a clear role to perform.

■ *A mechanism for participation.* The presence of a membership allows the Council to function as an inclusive organization. This moves the responsibility for building a community wide support system from the hands of a few to the entire community. It allows for broad community input while also developing a basis for change. The inclusion of many and the existence of working councils allow the council to avoid stagnation through the new ideas, agendas, and perspectives of Council members.

■ *Administrative pathways.* The creation and location of the Family Council allows administration to follow community decision making. The Council, which is seen as owned by the community, has the administrative capacity to quickly follow up on infrastructure decisions which are made. For example, the decision to pool funds was made easier in this community by the presence of a commonly owned entity like the Family Council. The Council is the repository for those pooled funds. The Council is located within the county system which allows for public scrutiny of the use of these funds. Another example includes data management, with the Council serving as a place for other systems to share information across systems.

■ *The centrality of parents and families.* Families are central to the mission and daily operation of the Stark County Family Council. Family members are employed and engaged on all levels in the county including policy making, administrative, direct service, and community. Six parents sit on the Board of Trustees as full voting members around policy and oversight. Parents are also represented on the ACCORD as full members of this quality review of individual child and family plans. Through the federal Center for Mental Health Services grant, Stark County has been able to hire parents as advocates and service plan facilitators. Finally, through the facilitation of FACES of Stark County, a vital component of parent involvement and supports also exists.

Clearly, this community has put a lot of thought into the development of long term infrastructure in an effort to build a system wide response to children and families in need. In reading about this structure it would be tempting to see this as creating another layer of bureaucratic response to children and families. The Family Council has taken great pains to avoid this. The Council uses existing administrative procedures to get the job done. The Council does not have appointing or hiring authority; the Mental Health Board acts as the employer of record. Fiscal streams are combined into a Family Council line item through the County

Auditor with the Stark County Community Mental Health Board acting as an Administrative Agent. The annual budget is approved by the County Commissioners.

While the elements of the infrastructure are complex, the Stark County Family Council has moved to where it is today through a strong emphasis on relationship building. Pre-dating the existence of the Council, this community has a history of system chiefs engaging in guided, creative thinking processes. Those creative planning retreats included concrete products and follow-up assignments but also allowed System Executives to get to know each other on a personal basis. These early relationships became the foundation for the structuring of a system designed to meet the needs of children and families.

Building Systems of Care:
New Opportunities

Eugene, Oregon

Bruce Abel, Director

In 1994, Lane County, Oregon received funding from the Center for Mental Health Services to enhance its system of care. The county, a blend of urban and rural communities, boasts a population of approximately 400,000 persons and is about the size of the state of Connecticut. The Federal funding was used to establish a project called *New Opportunities* which targeted children and adolescents age 0-22 who were experiencing serious emotional disturbances and their families. Eligibility was determined by the severity of the mental health problem, multi-system involvement, and the need for individualized services to support the family. The mission of the project was to promote a family driven, integrated system of care based on best practices. Specific values, goals and objectives were defined at the initiation of the project.

The primary goal was to build a system of care that included enduring service improvements, improved outcomes, and increased service coordination. A new governance infrastructure was developed to serve children and their families in an integrated and comprehensive manner. Public allied child-serving agencies and private provider agencies were involved partners. This partnership philosophy promoted a system of shared responsibility for the care of children including interagency linkage, cross training, shared staffing, and shared agency resources. Expected outcomes included: 1) a reduction in the number of, and length of stay in, out-of-home placements for children, 2) increased school attendance, 3) lower criminal recidivism, and 4) higher family satisfaction. Emphasis was on parent involvement at all levels of system planning and design and in the development of individualized plans of care for their children. Contracted agencies were required to increase family member involvement in agency activities, board meetings, and advisory boards.

In the first year of the project, the goal was to build a core of individuals who shared the vision as well as forging alliances based on values, not economics. Families were to be involved at all levels. In order to facilitate the involvement of agency representatives and community members, the following project structure was established:

■ *The Directors Team* was responsible for providing project leadership and for final decision-making and was composed of agency heads, community representatives, a County Commissioner, family representatives, cultural representatives, and the *New Opportunities* Project Director.

■ *The Operations Team* was responsible for the oversight of the development and implementation of the *New Opportunities* project. The Operations Team was composed of

middle managers, clinical supervisors, and community and family representatives. Several ongoing advisory groups were established as well as a number of time-limited, task oriented work groups.

A primary community value was that *New Opportunities* would not be a short-term demonstration project, but would represent the establishment of a new way of doing business. The time demand on agency staff throughout the system of care was extensive during the first year. Some participants felt that too much time was taken in planning and development prior to the beginning of service provision.

To best achieve a sustainable system of care, the Operations Team recommended a model that dispersed staff and service provision, rather than a centralized model. It was hoped that the dispersed model and the family and community involvement in planning would promote a significant system-wide ripple effect where a family friendly approach with cross agency coordination would become the norm. *New Opportunities* funded 15 Family Support Worker positions that were dispersed in 15 different public and private child and family serving agencies. Service improvement recommendations included: involving parents in developing individualized family plans, developing family teams, basing treatment decisions on family strengths, establishing a wraparound approach and process, dedicating flexible funds, and establishing a family safety plan.

Immediate benefits and successes from this implementation strategy were evident. The process promoted community excitement and involvement. Dedicated, cross-system participation focused on improving how systems worked rather then promoting self-interest. Differences brought to the table by participants were viewed as a system's strength. Agency directors conceptually supported the project and agreed to review their agency policies and procedures, as well to consider alternative funding possibilities. Most line staff supported the family centered, strength-based approach. A significant, immediate expansion of the role of families in the mental health system was evident. As families expressed their service preferences, new services were developed such as expanded recreation opportunities, respite, behavioral support specialists, social activities, and coordinated case management.

In order to test the service model and to make improvements in the service design, 25 families were enrolled as "pilot families". These families and their planning teams provided feedback to help make immediate improvements before the project was fully implemented. During the second year of the project, an additional 200 families were enrolled.

During the third year, a mid-course correction process was initiated to identify significant benefits and barriers to success. The intent of the mid-course correction process was to survey providers, parents, and community partners to identify best practices by determining does and doesn't

work. It became clear that implementing systems of care requires going through predictable developmental stages and that what works best in one stage may become a barrier in a later stage. System adjustments must be based on the reality of local and State political pressures, policy considerations, and funding changes. It also became evident that for *New Opportunities*, our focus, effort and financial support needed to be directed to where system reform was working best, rather than where the most significant obstacles existed.

The following barriers were identified:

- Agency staff, primarily middle management, were not sufficiently involved in or supportive of the service changes that were being implemented.

- Providers of *New Opportunities* services were too dispersed, resulting in insufficient consistency, service coordination problems, and inefficiencies. The time commitment of staff throughout the system of care was too intensive and not sustainable. In particular, clinical staff whose salaries were dependent on generating fees voiced reluctance to attend meetings that did not generate income.

- While family involvement in most of the mental health agencies became the norm, other public systems did not incorporate family member participation as an agency value.

- The governance structure worked during initial implementation, but worked less well during integration and formalization stages of development. Formal interagency agreements around staffing, agency procedures, coordinated contracting, blending funds, and other system improvement commitments became necessary.

- A structural impediment to achieving broader system change and to resolving the barriers listed above was the Project Director's role as manager of the child mental health system. He was not empowered to implement changes in any system other than mental health. Public allied agency directors were cautious and wanted data demonstrating cost and outcome benefits.

- The environment shifted. A local tax reduction measure reduced public agency budgets significantly. Agency directors became less willing and able to assume risk for *New Opportunities*. In addition, state-initiated changes overpowered local initiatives. The entire public mental health system was integrated with the Oregon Health Plan and became a capitated, managed-care system. Adult and Family Services implemented welfare reform while Services to Children and Families initiated a system of care approach, based on their positive experience with *New Opportunities*.

It was time for mid-course corrections. A community planning process, culminating in a facilitated retreat, resulted in significant project changes. The existing governance structure was changed to involve more "system funders." These public agency stakeholders began to develop strategic plans for achieving common service and funding goals based on shared outcomes. Family

Support Worker positions were relocated to child-serving governmental agencies that had the potential for long term funding support. The focus on youth with a serious emotional or behavioral disorder was expanded to include a broader safety net. *New Opportunities* was integrated with Lane Care, the Oregon Health Plan mental health managed care organization.

Many lessons were learned during the course of this project. Most important was that creating a "project" that stands by itself couldn't create lasting change. System reform and change efforts must be embedded in the current system rather than being some new, separate, Federally funded program that will be present for a few years and then will disappear. Out of the experience of *New Opportunities*, the following recommendations emerge:

- The Project Director must work in partnership and at an equal level with the significant system change agents (public agency directors, school superintendents, etc.) to define vision, goals, strategies, and commitments. Specific change recommendations must be based on system strengths and needs and be fully supported by agency directors and system funders. Middle management staff must be involved in the design and operationalizing of system improvements. Inter-agency agreements should be completed to define changes and commitments.

- The governance structure must involve parents, providers, line staff, and community representatives in meaningful ways. Advisory groups should understand their role as making recommendations. Decision making processes should be clear. Decisions should be documented, communicated, and implemented.

- Sufficient funding should be allocated for infrastructure and communication costs (staff time, newsletter, and computer) to support a system of care. Investments in clerical support and other staff will pay off. Participant involvement in all the meetings takes time, and family members and program staff should be compensated for their time.

- Cross-system communication is essential. Keeping all partners informed is a challenge.

- The community must own the system of care. The project should initiate a strategic public information campaign. Each community and each developmental phase should produce a unique product and process. Participants must trust the process, turn it over to the community, and let what is developed really meet community vision. Over time, the model should be expanded to include all children and families by integrating all service providers in the vision and values of a community-based, family-focused, flexible and individualized system of care.

Input ... or Power?
Philadelphia's Family Advocacy Initiatives

Philadelphia, Pennsylvania
David Fair, Project Director

The Philadelphia Office of Mental Health and Mental Retardation, with the support of a grant from the Center for Mental Health Services, has been engaged in an effort to institutionalize the concept of a "seamless system of care" for children with serious emotional disturbances and their families. This project, now in its fourth year, has sought to achieve two major objectives: 1) to establish a network of school-linked behavioral health services for children in a severely underserved area of South Philadelphia, and 2) to reform the child-serving system generally to better integrate behavioral health services into a comprehensive system of care building on the strengths and responding to the needs of families. Significant effort and resources have been dedicated through this project to overcoming the various institutional boundaries, conflicting mandates, and competition for resources that frequently fragment services delivered by governmental and community child-serving agencies. This short overview of the project focuses on one aspect of this system of care reform initiative: empowering family members and caregivers to play truly meaningful, and permanent, roles in designing, leading, and participating in the children's system of behavioral health care.

OVERCOMING TOKENISM

The philosophy of true family involvement and advocacy in the system of care for children with serious emotional disturbances is hardly foreign to Philadelphia's Office of Mental Health. Since the late 1980s, under the leadership of Estelle B. Richman (initially as Director of the Office of Mental Health and, since 1993, as Health Commissioner), system design and service delivery have formally been accountable to families through a variety of processes and procedures. On the system level, these typically involve formal advisory bodies comprised of significant consumer/family representation; use of consumers and family members as consultants and staff in actual service delivery; family satisfaction surveys, studies, and structured evaluation programs, the institutionalization of formal family/consumer satisfaction "teams," whose feedback and advice provide critical information to program design, provider training, quality assurance efforts, program and provider evaluation, and, in many cases, a determination whether a service continues to be supported by public funds. Consumers and family members have also played a pivotal role in developing the Behavioral Health System — Philadelphia's system of behavioral health services for Medicaid recipients and uninsured children and their families — serving on virtually all boards, committees, and ad hoc groups which played a part in designing Community Behavioral Health, Inc.

With the implementation of the federal grant project — itself the result of family advocacy efforts which demanded that the Office of Mental Health recognize the urgency of strengthening its assistance to kinship families — the opportunity arose to experiment with even stronger models for assuring family involvement in the publicly-funded system of care for their children. Family representatives involved in the design of the grant project recommended that, through this initiative, the system of care could build on our collective experiences and demonstrate that we could move beyond mere "participation" in the system to a level of influence and control that had not previously been achieved by families of children with severe mental, emotional and behavioral disorders in Philadelphia. The basic principle of this new family advocacy initiative was that the child and the family are not "recipients" of services, nor merely "consumers" of services. Rather, families and their children are the foundation of the system of care — its reason for existence and the arbiters of what it should include, how it is run, and ultimately, whether or not it is working. This effort also recognized that, despite the sincere intentions of governmental and provider agencies, most "family participation" models had been more successful on the individual case level -- that is, involving the parent or caregiver as a true decision maker in determining what the system is doing to help their individual child -- than they were on the "system" level, where the culture, context and framework of the service delivery system were developed and enforced.

IMPROVING FAMILY PARTICIPATION AND POWER

The plan of the Partnership to improve family empowerment in all aspects of the delivery of behavioral health care to their children operated on several important levels. While the incorporation of the principles of the Comprehensive Community Mental Health Services for Children and Their Families Program has been formally an element of every response to the needs of children with serious emotional disturbance and their families for many years in Philadelphia, the grant project recognized that assuring appropriate family decision making and involvement in the new and expanded services being developed in the school setting provided an opportunity for us to further institutionalize these principles. The traditional reliance of school programs on the involvement of parents and family members also provided additional "leverage" on sometimes reluctant service providers to give more value and weight to the critical importance of family involvement in their child's care.

The South Philadelphia Family Partnership developed school-based intensive case management services, as well as other mental health services, staff training programs and linkage to community social services, in nine Philadelphia elementary and middle schools. These services were firmly integrated into existing school multi-disciplinary processes, involving principals, school counselors, teachers, and other school staff. At each level of intervention with a child, the regulations of the Partnership program require parental or caregiver involvement in all meetings; require

parental/caregiver consent on all behavioral health and educational plans; and encourage family members to seek the assistance of family advocates, legal assistance, and other support if required to assure that the family's wishes are respected by the service delivery system.

Family Advocacy

The Partnership further recognized that simply guaranteeing family involvement would not be adequate if families were not able to draw on the kind of experience and advice that has often only been available to the professionals with whom they come in contact. To assure that family members had access to independent advice and counsel from other family members who had more experience in working with professionals in addressing the needs of their children, the Partnership engaged in a professional services contract with two community-based family organizations -- the Parents Involved Network, a statewide coalition of families of children with emotional and behavioral disorders, and Raising Others Children, a neighborhood coalition of grandparents and other kinship caregivers. Support for Parents Involved Network and Raising Others Children involved the following activities:

■ *Family Advocates* – Utilizing grant funds, the Partnership supports three full-time Family Advocates, whose sole purpose is providing support to families receiving the help of mental health service providers. The Family Advocates provide individualized advice to families in proposing appropriate system responses to the needs of the child; accompany families to meetings with professionals held to develop or evaluate service plans; assist families in linking to legal advocacy when appropriate; provide emotional support to families as they confront their concerns, evaluate options, and challenge providers to respond adequately to the needs of the child; and link families to the network of families of children with emotional and behavioral disorders who are organized as a constituency to influence public policy. Family Advocates also facilitate support groups, conduct educational programs, and generally act as an independent resource for families participating in the system of care.

■ Utilizing other funds, the Office of Mental Health has also funded a full-time position called *Managed Care Family Ombudsperson*, a trained family member, employed by Parents Involved Network, with the responsibility for advocating for individual families participating in Community Behavioral Health, the local managed care program for Medicaid recipients. This individual works with staff of Community Behavioral Health, Inc, and licensed providers to assure that the system works smoothly for families and that special needs and crises are addressed rapidly. Additionally, the Ombudsperson serves on a variety of Community Behavioral Health, Inc., policy bodies to assure that the family perspective is heard and accommodated as their policy and programs are implemented.

■ *Kinship Services* – The Partnership also supports a full-time *Kinship Services Coordinator*, who is responsible for providing special advocacy and support activities to kinship families receiving behavioral health services. Through this initiative, individualized family advocacy services

are provided, as well as staff training and program development services. Through this initiative, several special kinship initiatives have been implemented, including the creation of Grand Central, Inc., a new, independent non-profit corporation which acts as a centralized resource center for kinship families throughout the Philadelphia region, and which links kinship families to behavioral health services, legal advocacy, social services, support groups, and a wide variety of other services needed by kinship caregivers. This activity has also drawn support from local foundations, the Philadelphia Dept. of Human Services, the Pennsylvania Dept. of Public Welfare, and other community organizations.

■ *Resource Information and Referral Services* – The Partnership additionally supported the research and publication of a *Children's Services Resource Directory*, which provides detailed listings of available behavioral health services for children and their families, information on how to access care through managed care, and general advice on what to look for when seeking mental health services and how families can best advocate for their child. A specialized resource bank is also being developed targeted to kinship caregivers, as part of the Grand Central project. Finally, the Partnership supports a *Family Help Line* which provides direct telephone information and referral services to families. The Help Line has been advertised through an extensive public information campaign involving television and radio public service announcements, advertisements in community newspapers, and a poster campaign on the area public transit system.

SYSTEM-LEVEL INITIATIVES

Fundamental to our efforts to improve the "power" of families over the system of care for their children has been an understanding that even the best-intentioned efforts can devolve to mere tokenism unless the system itself is designed to support them. Families must also have the ability to hold the system accountable in meaningful ways in achieving the objective of true family empowerment. The most important mechanism in place to assure family influence over the planning and implementation of system of care initiatives is the *Partnership Advisory Board*, which brings together public agencies, providers, and family members for the purpose of setting the overall agenda of the project and determining strategies for program development, sustainability, political credibility, and evaluation of the project's activities. Unlike other advisory boards which have been established in the past at the Office of Mental Health, the Partnership Advisory Board is comprised of a majority of family members, and includes both families actually receiving services through the Partnership itself; other family members receiving services through other Office of Mental Health and Community Behavioral Health, Inc. programs; and representatives of the formally organized family coalitions, the Parents Involved Network and Raising Others Children. Family members also have the leadership role in individual committees and workgroups of the Advisory Board, including the *Community Awareness Workgroup*, the *Evaluation Workgroup*, and the *Core Management Workgroup*, which oversees grant activities on a more immediate basis for the entire Advisory Board when it is not in session.

In these roles, family members have played a decisive part in designing localized family satisfaction and program evaluation projects developed as an adjunct to the national evaluation sponsored by the Center for Mental Health Services. They have also determined all of the community awareness initiatives implemented by the Partnership, including both materials design, message development, and determination of methods used by the Partnership to convey its message and market its activities. Families have also been a part of the decision making process as it relates to resource allocation for new initiatives including grant support for a kinship caregiver respite program called *Family Friends*, a new out-patient and wraparound service center to address the lack of culturally competent providers in South Philadelphia, called the *Philadelphia Youth Advocate Program*, a specialized after-school program for children with serious mental, emotional and behavioral disorders as well as other children believed to be at risk, called the *Saturday Academy*, and a therapeutic summer camp program, initially operated by Raising Others Children and now provided through a collaboration between Raising Others Children and Philadelphia Youth Advocate Program. In addition, they participated in the development of new guidelines for school-based wraparound services, which after a trial period, will be implemented throughout the Philadelphia school system in September 1998, and in the planning for a pilot project on Multi-Systemic Therapy to be implemented in the 1998-1999 school year with support from the Casey Foundation and other sources.

In sum, family members, who have been involved intimately in the design and development of these programs, have identified virtually all initiatives developed by the grant project. As a result of these activities, family members have been incorporated at all levels of children's behavioral health services in Philadelphia — as managers, as advocates, as planners, as evaluators, and as service delivery staff. Accomplishing this has required an essential willingness on the part of service providers and city agencies to step back from their traditional roles and entrust family members with real authority over planning, decision making, and resources. Our efforts to date have resulted in a true partnership between family members, planners, experts, and providers in which all of us play our important roles, and in which all of us have learned to recognize that the children and families with whom we work are ultimately the judges of our success.

Building the System of Care through Training: The Service Coordination Curriculum

Project REACH, Rhode Island

Susan Bowler, Project Director

> *I am very glad I took this training . . . . Your course gave me some images to mull over; your book, a road map and dictionary/encyclopedia — now it is time to get back on the trail - back to the journey of this life, a bit road weary, but conscious that I am not alone, and that I will persevere. I am here to stay and will get my children and myself what we need. It is all a matter of time and perspective.*
>
> *— A Parent's Reflection*

> *This training has helped me work with families in a more integrative approach. I have also been able to look at how I viewed a family and make them the focus . . . . I cannot help a family if I do not listen and respect the family or if I do not first know and understand what I, as a person, bring into the relationship. This has been learning and growing experience.*
>
> *— A Professional's Reflection*

With the assistance of the Center for Mental Health Services, Rhode Island has made a substantial financial and programmatic commitment to training and technical assistance for system of care participants. These activities are used to share what we have learned, and they provide a way to regularly bring parents and practitioners from a wide range of disciplines together to build relationships, generate new information, and refine the system of care. Training is strategic and formative for the system of care and, therefore, is developed through mechanisms that represent and give equal voices to the system's constituencies.

The Service Coordination Training implemented in our site is the primary curriculum-driven training vehicle for present and potential participants in the system of care. Initially conceptualized as a case management tool for parents and professionals in crisis situations, the training has become one of the critical mechanisms through which the basic values that underlie the system of care movement in Rhode Island are reflected and reinforced. This four-day, 12-module training provides information on topic areas including state mental health, child welfare, special education, crisis planning, transition to adult life, legal rights, and confidentiality; it also offers skills training in building family and professional partnerships, collaboration, communication in the face of conflict, and fostering cultural diversity in child and family serving systems, as well as guaranteeing sensitivity to each child and family's culture in developing individual service plans. A parent/professional team from the private or public sector teaches each module.

Creation of the curriculum has been evolutionary, with many exciting and ennobling moments — and with a fair number of rocky stretches and bumps in the road. Approximately 250 people have participated in nine separate offerings since 1995. About a third of them are parents; a third are mental health/social service professionals, and a third educators. This training initiative is a joint effort of the Department of Children, Youth, and Families, the Department of Education, and the Rhode Island Council of Community Mental Health Centers. Both departments have committed state and federal money to support the effort and have worked closely with the Council in its development, implementation, and evaluation. The Rhode Island Council of Community Mental Health Centers is a nineteen-year-old association representing all of the state's community mental health centers. The Council provides advocacy, education, and coordination services to and on behalf of its members and the persons they serve.

The Council became the lead agent for the Service Coordination Training because of its long standing experience in providing training and technical assistance to mental health professionals and para-professionals working in the field. A certification program for case managers employed in community settings in the adult mental health system also designed by the Council has been in place for more than a decade. *Project REACH Rhode Island* has consistently utilized a strategy of building on and penetrating resources already existing in the field as the system of care for children and adolescents was developing. In late 1993, the Department of Children, Youth and Families asked the Council to convene an Advisory Committee to oversee the development of the curriculum for a certificate-bearing training program. The Advisory Committee would bring together mental health professionals, educators, and families who are involved in these systems through the needs of their children. The training director of the Council provided leadership and facilitation for the effort. Initial efforts of the advisory body centered on the coordination of focus groups; gathering, disseminating, and organizing research information; identifying strategic alliances; and building collaborative relationships with critical partners. Early in the planning it was clear that the curriculum would adopt the system of care approach with a focus on the principles of cultural sensitivity, family generated case management, and interdisciplinary collaboration.

This deeply committed and representative Advisory Committee of parents and professionals from education, social service, child welfare, mental health and juvenile justice has guided the development of the Service Coordination Training with ongoing parental, provider, and community involvement for the last five years. It has brought the voice of the community into system development in a consistent and dynamic decision-making process.

Several lessons have been learned over the last five years. Perhaps one of the earliest lessons was that you can't succeed without trying and you can't always be successful when you try. Experimentation and risk taking are essential for successful system development. Whether designing effective training, outreach, prevention, or treatment, all system participants must know that honorable efforts to create new knowledge and better ways of working together will, in fact, be valued.

In the words of Thomas Edison, "I have not failed 10,000 times. I discovered 10,000 ways that didn't work." Each of the lessons learned described below was learned through a process of outreach, information gathering, strategic planning, implementation, monitoring, and revision. Modules have been changed, the style and format of delivery altered, and instructors have been recruited or replaced on the basis of the unfolding experience of participants in the training and in the broader system of care.

Recognize and respond to the needs of adult learners. Because it is an extensive, four-day event, the Service Coordination Training is a major commitment on the part of participants and their families or professionals and provider agencies. If this kind of commitment is to be made and sustained, training has to be of surpassing value to participants. Participants have confirmed us, and our experience has demonstrated that principle.

Participants must receive concrete useful information in usable form. Examples of some kinds of agencies that might provide some assistance is only somewhat helpful; specific leads — provider lists with contact people's names, resource directories, organizational charts with names, job responsibilities, and phone numbers for important community partners — are life savers for parents and providers navigating the system of care.

Information must be relevant to real world needs and consistent with core values. Discovering the content that would appeal and be helpful to such a diverse audience has been an on-going project. The evolution of information provided in the module on child welfare is a good illustration. Initially, the training focused on recognizing signs of child abuse and neglect. As experience accumulated, parents and professionals on the Advisory Council became extremely uncomfortable with this approach. For one thing, all feared passing on what, in light of time constraints, could only be very introductory information that could actually be misleading and dangerous. For another, professionals and families questioned the message that was being transmitted. Why would a service coordination training for children with serious emotional disturbance focus on uncovering child abuse? What were we inadvertently saying about families?

What we now present is an overview of the state's child welfare system, public and private, with recommendations on accessing all services. Within this context, we discuss Child Protective Services and legal and ethical issues relating to reporting child abuse or neglect. This provides the vital system navigation information for parents or professionals who, in the course of their work with the system of care, are confronted with child abuse or neglect which must be reported or who are working with children who have serious emotional disturbances and are already in the child welfare system.

Participants must have structured opportunities to work with the skills and information that they are receiving. Training is divided between morning sessions that offer a great deal of

information and afternoon sessions in which participants have opportunities to put into practice and discuss the ideas and skills they have heard and talked about. We also make sure that morning and afternoon sessions are in different rooms, and participants have opportunities to physically move around and partner with different people and groups of people. Order, flow, and variety greatly impact the success of the training. Participants have given us a great deal of information about shaping the training over the last five years and we have paid very close attention to their suggestions.

Participants bring a great deal of skill and knowledge to the table. As adult learners, participants will have a great deal of training and/or life experience about the material being discusse Enlisting them in discussion and inviting their insight increases the knowledge base for each and every module, but also makes "losing" them less likely. For example, the Director of Special Education from one of the state's leading cities already knows much of the information that will be presented in the special education module. The last thing that the Advisory Council wanted was to have the Director skip that session. Establishing a culture of drawing on the knowledge and skills of the participants gives everyone a reason to keep coming. Moreover, parent involvement in providing training only begins with parents as co-trainers for each module; if parents share lessons they have learned, the group's experience with parents as partners is greatly deepened. Drawing on the life experience of these adult learners reinforces the core value of collaboration: mutual respect and teamwork. Because of the breadth of the curriculum, all participants at some point in the training will be expert "teachers" and open "learners."

Participants want to have some fun. Skill building exercises can and should be playful as often as possible. Because of the nature of this training, some modules generate great passion and can verge on the painful and difficult. Consciously building in some enjoyable exercises is an important way of nurturing the group. It's also a welcome and effective way to keep the learning alive by late afternoon.

Partnership with parents/family members doesn't just happen — in training or in system development. Developing parent/professional partnerships has to be energetically sought and systematically cultivated.

Recruiting parents/family members to serve on the Advisory Board has and continues to be the focus of a great deal of energy and outreach. At the outset and over the last five years, a conscious focus of the Advisory Committee has been the recruitment of parents and family members to serve in all capacities related to the training. This recruitment activity is a goal and strategy in and of itself to which energy, time, and resources must consistently be committed.

Establishing an atmosphere of collaboration and trust between parents/family members and professionals during the training is one of our first goals. If the training is to be system building, all participants must leave more committed to the system of care and anxious to act as partners within it. Many come to the training with bad experiences and great anger or frustration toward some of the other groups who are also participating. If not confronted directly, this baggage can be very disruptive and actually sabotage the training.

A guidance counselor, for example, attended one of the first training sessions with a goal of learning how to better meet the needs of the children and families she served. After introducing herself to the group, she identified her limited knowledge of mental health and other related systems as a major barrier in her ability to serve children in school. A parent, who had had very difficult experiences with school guidance counselors, reacted with great frustration and outrage. While the trainer tried to help establish a dialogue between the participants, the guidance counselor's sense of safety was too badly damaged — she never completed the training and has not participated since in the system of care.

The Advisory Committee realized that team building needed to be the first order of business in bringing together such a diverse group with, in many cases, a very complex history. Now, the training opens with a series of exercises in which participants together explore expectations and previous experiences and establish guidelines for discussion.

Committing to parent/professional co-training of each module is just the beginning. We had very little idea, five years ago, how much we had to learn to operationalize our vision of parent/professional co-training. In the first sessions, family members with a clear interest and experience in certain topics paired with professionals with similar interests. Family members were invited to participate as much as they wished in the presentations. Meetings for trainers focused on developing a clear, common understanding of the goals of the system of care and the role of the training in fostering them as well as practical solutions to identified concerns. To our surprise and chagrin, what evolved was that the professionals presented the bulk of the module and the family members offered a "parents perspective." The construction of a real parent/family member/professional training team had to become the focus of training for trainers in and of itself.

The Council Training Director met with presenters to review evaluations, strategies, and training content, and to develop classroom materials. All had to meet the test of true partnership in both development and presentation. Evaluations and experiences of trainers and participants have been consistently monitored by the Advisory Committee to make additional adjustments as necessary.

Acting on this principle in all decisions relating to training is essential. What has moved us from a portrait of partnership to the "real thing" has been a willingness to take concrete actions in support of our vision, even when these are painful. For example, some very successful and well-respected community trainers, professionals and parents alike, have been unable to make the transition to full teaming in presenting their modules. Those who cannot model the vision, after reasonable support and discussion, are not retained as trainers. We have found that constant water testing, to make sure that the vision and the practice are in sync, is essential and that the system must have a capacity for consistent corrective action.

Leave your assumptions at the door. In Rhode Island, almost every Service Development Training has uncovered parents/family members in positions of significant professional responsibility. Converting these folk into allies and advocates for the system of care is one of the most critical tasks of the training. Part of our team building is preparing all participants for surprises and encouraging them to act positively and strategically on these revelations.

The value of a committed, representative, and energetic Advisory Committee cannot be overestimated. Modeling the system we seek to build in the Advisory Committee was of paramount significance in the success of the effort. This representative group understood the needs of the system because they lived them. They also provided credibility to the often complex process and decisions that had to be made. Finally, the Committee provided important continuity to the effort. Though still young, the Service Coordination Training now has five years of history. It has been extremely helpful to have a locus for institutional memory and a reservoir in which to collect the accumulated wisdom of the participants.

The Never-Ending Journey Towards Cultural Competence in the Charleston Village: If It Doesn't Feel Like Help, It Isn't

Charleston, South Carolina

Barbara A. Trout, Director

The *Village* is the name given to the system of care in Charleston, South Carolina for children and adolescents with serious emotional and behavioral problems and their families. Initiated in 1993 with federal and state funds, the name was taken from the African proverb, "It takes the entire village to raise a child." At first, the term *Village* was seen as a catchy name for a grant proposal. However, we quickly realized that the *Village* could signify a way of doing business that includes delivering services in a culturally competent manner, understanding and honoring the family's definition of "help," recognizing the strengths of communities and families, and sharing resources. Since awarded the opportunity to implement the system of mental health care for families in Charleston, our goal has been to honor the meaning behind the name, the *Village*. Some days we act more like a *Village* than other days, but the *Village* vision is ever present.

One of the first steps we took in creating community awareness and ownership of the *Village* was to ask community members, adult and youth, to submit designs for a *Village* symbol. The design, created by a family member, is an imaginary mix of the Baobab and Oak trees, signifying the protection of all the children in our community. Our community is primarily bi-cultural, where about 64 percent of the residents are white, 33 percent are African American, and 3 percent are Hispanic, Asian and Native American.

In the *Village*, we define cultural competence as the delivery of services that are valued by and respectful of all members of our diverse community. We have adopted the vision of "help" developed by the Institute for Families in Society at the University of South Carolina which is that "families should be able to get help where they are, when they need it, in a form that they can use it, with ease and without stigma" (Melton, 1997). *If it doesn't feel like help, it isn't.*

Our journey toward a culturally competent system of care is described from the perspective of the South Carolina Department of Mental Health, the lead agency responsible for implementation of the *Village*. Since "one size fits all" applies to T-shirts but not to families, professionals or communities, we hope that the ideas offered in the next pages will be modified and adapted to fit the needs, values, and cultural context of the reader.

The first step of any journey is to *begin.* This requires at least one person to go on record as

saying that cultural competence is important. This one person then seeks out one more person willing to go on record, and so on, and so on, until a crowd of folks have agreed to begin the journey. By our definition, as few as two can constitute a crowd in the beginning. The support of this group will be important as you face the many barriers that will crop up to de-rail the Process of Cultural Competence.

In South Carolina, the Department of Mental Health provided strong leadership in beginning the journey towards cultural competence in these ways:

- The work being done at the federal level at the Georgetown University Child Development Center was brought to South Carolina by state level Mental Health officials. In particular, Dr. Jerome Hanley, Director of the Division for Children, Adolescents and Their Families participated in the development of the monograph series "Towards A Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed." Dr. Hanley was instrumental in bringing to South Carolina the vision, philosophies and strategies endorsed at the federal level and described in this monograph series. The work at the federal level grew from the recognition that families of color were least likely to access and benefit from available mental health services.

- The Department of Mental Health hired a full time Director of the Cultural Action Program Office, which develops and reviews policy and provides consultation and training statewide.

- A state level Cultural Competence Plan of Action was developed in 1994. All hospital facilities and community mental health centers were charged with implementing it at the local level.

Numerous state and regional training opportunities on cultural diversity and competence are sponsored by the Department of Mental Health throughout the year.

These activities mandated the institutionalization of cultural issues as a part of the service delivery offered through the *Village*. No additional staff resources were allocated from the Department of Mental Health to accomplish this mandate. However, extensive training and consultation from the Cultural Action Program Office was available.

At the local level, the Charleston/Dorchester Community Mental Health Center has been the lead agency for implementing the *Village*. One of the first things we did was make a concerted effort to change our language to be more respectful to families. These changes moved us from pathology-focused to strengths-focused assessment and service plans. The Center responded to the state mandate for cultural competence by establishing a Cultural Competence Committee. The Center director deliberately appointed a committee of members who represented diverse ethnic, age, gender, and religious groups in our community. In addition, at least two members are part of the Center's management team to assure access to the highest level of decision-making. The first meetings of this committee in 1995 were spent establishing trust among the group as personal experiences of culture were shared with a discussion of how this impacts service delivery and relationships, both personal and

professional. During this period, it is useful to frequently predict that the process of cultural competence is likely to create emotional discomfort. *Do it anyway.*

It is important to make sure that external people or groups are expecting to review the work that is accomplished. During the first year, our Cultural Competence Committee created a definition of cultural competence within the context of the work we do. We then used the state Plan of Action to write a set of recommendations for the Charleston/Dorchester Community Mental Health Center. After the Center's management team accepted these recommendations, a work plan was developed. Since then, an annual report of the goals achieved is distributed to the management team and all Center staff. The report also is part of the materials submitted to the external accrediting organization for the Center (the Council for the Accreditation of Rehabilitation Facilities). The original recommendations and the annual report are then used to develop the work plan for the next year.

Formal training should be provided early on in the process. It may be useful to bring in an outside presenter to get the conversation started. Often outside presenters are not bound by the history of silence about cultural issues that may exist. We learned early that it is important to describe strategies and policies, as opposed to people, as culturally competent or not competent. The process will be de-railed if people feel they have been judged as incompetent in this arena.

The training should describe the general characteristics of different cultures, but recognize that the information may simply be used to create or modify a stereotype that then is applied to all members of a group. The information can then be used to help staff gain a general respect for and recognition of differences, but it should also emphasize that the way to really understand the culture of an individual is to ask the individual.

Other activities to get the journey underway include the following:

- Select some relatively non-threatening activities such as a weekly or monthly reading and discussion groups, adding diverse reading materials to the waiting rooms and work areas, changing the artwork on the walls, assuring that cars used for home-based services are not readily identifiable as from the government or some other "helper" agency.

- Subscribe to both the mainstream newspapers and other publications as well as minority-focused ones. Collect and distribute articles from both that reflect positive and negative issues relevant to cultures that are real in your community.

- Begin to include discussions of culture, including your own, at every meeting. Structure ways for staff to include their own cultures when introducing themselves. Arrange a pot luck meal during a meeting where everyone brings a dish that represents their culture and have them explain it.

■ Do a self-assessment, both personal and at the service level. Make up your own or use one of the published ones that are available. We use the Building Bridges Assessment developed by La Frontera, Inc. in Arizona.

■ Change the name of your service if it does not reflect the community to which you need to be responsive. Create a symbol that reflects your commitment to cultural diversity. This requires knowing the members of your community and the diverse cultural contexts.

Sustaining the progress towards cultural competence requires the incorporation of these and other strategies into the everyday hustle and bustle of doing business. Cultural issues must become an integral part of all required paperwork, administrative meetings, service planning meetings, and training. For example, we added an item to the initial assessment for services that asked the helper to describe the cultural values and beliefs important to the family. Staff initially told us that they really didn't know what to ask except for where the family attends church. This led us to develop training in the area of assessing culture. We also mandate that the Cultural Competence Committee review all new and existing documents, brochures, questionnaires and so on, looking for the inclusion of relevant cultural information as well as language that might be offensive or exclusive.

Modify your hiring practices so that culture issues are addressed at the initial interview. This sets the expectation up front that cultural blindness (i.e.,diversity is not important or valued) will not be tolerated. We ask each applicant to provide a written answer to the question, "How will your culture and the families' culture be important in your work with him or her?" *Stop hiring and surrounding yourself with people just like you and recruit those who look more like the families served.* Acknowledge that it may take some effort to become comfortable with people not like you. We now require that a diverse team of interviewers meet with every applicant. We do not prescribe what the diversity should look like, just that different cultures be represented. This is important because we have heard from some applicants that when they are interviewed by a non-diverse group who are quite different from them, they wonder whether they will fit in and be comfortable.

Modify your staff supervision practices so that cultural competence is part of everyone's job description. Include an objective related to cultural competence on everyone's job/evaluation plan, along with questions about your agency's progress toward cultural competence during every exit interview with staff and families who are leaving your system of care. The exiting folks have the freedom to be quite honest with you.

The goal is to create choices for families and, whenever possible, to honor the family's preference — not to match every consumer family with a helper from the same cultural group. A diverse work force comprised of people who reflect the diversity within the community provides a ready pool of individuals from whom families can choose. Our staff talks openly with families during the initial meetings about whether there is anything about the staff, such as skin color, gender,

style, that might create a barrier for the family in establishing a good alliance and relationship for positive change.

Assure diverse representation at all levels of decision-making. Deliberately create diverse task forces and committees whenever the opportunity arises. During this process, predict that some folks will mistake your attempts to create diverse representation as tokenism. Be prepared to explain as often as needed that tokenism implies representation regardless of quality, and, in fact, sometimes at the expense of quality. Make sure that your strategies to create diverse representation do not compromise quality.

The self-assessments that you begin using at the beginning of the journey will provide information about which groups of people and communities you are simply not reaching with services that are valued and respected. As you learn about the folks you are missing, meet with representatives from those communities and seek their definition of help. Be prepared to modify your way of doing business to be respectful of the cultural context of each community. For example, we learned in one community that the stigma attached to endorsing mental health problems on a written assessment tool resulted in no families being eligible for services. We eliminated the need for a certain score on an assessment device and moved instead to an interview format where over time trust developed between the helper and the family such that mental health issues were identified.

Recognize that honoring family preferences is culturally competent. When we work with families with extreme prejudice, we accept the families where they are and do not see our role as seizing the moment to broaden the families' tolerance and respect for other cultures.

Recognize that creating services that will be sustained, as opposed to being temporary, is culturally competent. When developing grant proposals in our community, community leaders routinely note that the biggest mistake that a helper agency can make is to bring services to a community, develop trust, and then pull out because the funding runs out. The residents feel like they are being experimented on and that the real benefit is for someone else. This does not feel like help, therefore it isn't. With every new initiative, sustainability must be part of the original plan.

Make sure that your own house is in order before you invite yourself to advise others about how to move along the cultural competence continuum. Early on in our journey, our Center ambitiously invited other agencies to join us in a multi-cultural task force. We quickly learned that we had little idea of what we were talking about and even less idea of how to be supportive of and helpful to others. We did not know how to sustain the initial enthusiasm for cultural competence within other agencies until we had made substantive policy and procedural changes within our own agency.

In closing, we know that we are not done learning yet. We thank the many families and helpers at the federal, state and local levels who have helped us on our journey. We look forward to our future lessons in this journey, which, by definition, has no end.

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Access Vermont

Burlington, Vermont
Brenda Beene, Project Director

The site for the State of Vermont's grant project is the whole state. Vermont has a total population of about 584,771 (according to the Vermont Population and Housing Estimates from the Department of Health, 1996). This includes approximately 146,760 youth under age 18. Chittenden County has 24 percent of the state's population and is the only standard metropolitan statistical area in Vermont. More than 98 percent of the population is White, though the cultural and ethnic diversity among young children is somewhat higher due to many trans-racial adoptions and the settlement of refugee families. The majority of the small number of African-Americans (less than 1 percent of the population) live in the greater Burlington area, which is part of Chittenden County. Burlington is home to a community of Asian-Americans, and there are small clusters of Native Americans and families with close ties to their French-Canadian heritage in the northern counties.

Vermont is one of the most rural states in the country. Certain areas, especially the four most northern counties making up Vermont's "Northeast Kingdom", are particularly isolated and impoverished, with many residents having little access to mental health or other human services. This isolation, plus Vermont's' traditional independence, self-reliance, and reluctance to seek help, may contribute to the State's being ranked eighth in the nation for youth suicides (14.6 per 100,000 according to Center for Disease Control statistics).

Overall, the number of children being raised in poverty in Vermont is estimated to be 15.79 percent, or 23,173. The federal Center for Mental Health Services estimates that there are between 4,590-9,180 youth ages 9 to 17 with serious emotional disturbance in Vermont. Though over half of the children and youth served by community mental health centers are experiencing serious emotional disturbance, the centers reach only a small percentage (under 20 percent) of all the children and youth in Vermont who are experiencing serious emotional disturbance. Thus, there is plenty of need to increase and "*Access Vermont*" mental health services.

Two high-priority populations for services under *Access Vermont* are the following groups of children experiencing serious emotional disturbance and their families:

> 1) children, adolescents, and their families experiencing a crisis situation that threatens the stability of the family and may place the child at risk for being removed from the home and/ or school or day care; and

2) Children and adolescents experiencing the most severe emotional and behavioral disturbances and the most challenging family circumstances that place them at high risk for being removed from their homes and/or school or day care and from their communities.

COMPONENT/CATEGORY CHOSEN FOR DISCUSSION

"Building Systems of Care" is the topic chosen for discussion under lessons learned from *Access Vermont* because implementation of this grant has contributed significantly to the development of the State of Vermont's human services infrastructure.

Vermont's official infrastructure consists of state and municipal government. The 246 cities and towns are organized into 60 school supervisory unions. Though 14 counties exist, there is no county government except for Superior Court. Most of State government is operated through regional offices placed in nearly every county. Over the last 30 or more years, a variety of regional entities have been created to foster collaborative approaches to solving human service, economic, environmental, or other problems which neither schools nor municipal or State government could adequately address alone. A wide range of human service associations and groups exist in Vermont, many as private, non-profit organizations and some that are publicly-mandated, such as the Act 264 State and Local Interagency Teams for children who are experiencing serious emotional disturbance. The most comprehensive associations are the twelve Community Partnerships recently jointly sponsored by the State Agency of Human Services and the State Department of Education. These Partnerships conduct business for the State but are not official State entities. *Access Vermont* was instrumental in the formation and strengthening of these Community Partnerships.

Community Partnerships exist in each of the twelve Agency of Human Services districts. They operate in conjunction with a State Team for Children and Families that was created in 1995 to achieve greater collaboration at the State level and to foster strong partnerships with community/ regional collaborative groups devoted to improving the well-being of children and their families. The State Team and the Agency of Human Services obtained funding from the Annie E. Casey Foundation and the federal Justice Department's Caring Communities Program to staff community groups to conduct needs assessments, planning, collaborative service delivery, cross-disciplinary professional development, blending of funds, and system-wide performance and outcome evaluation. These activities and funds boosted pre-existing *Access Vermont* groups into more formal Community Partnerships.

What Worked

In 1994, for *Access Vermont*, the State Department of Developmental and Mental Health Services — in collaboration with the State Department of Social and Rehabilitation Services —

required the Act 264 Local Interagency Teams in the 12 Agency of Human Services districts to develop Regional *Access Vermont*/Family Preservation Plans. The Local Interagency Teams were instructed to convene groups of service providers, parents, and community members to create, implement, and oversee Plans to reduce the number and rate of children unnecessarily entering State custody, especially on emergency detention orders.

This step into community planning and governance was a natural outgrowth of the Child and Adolescent Service System Program Services System Program which the Local and State Interagency Teams had been doing in Vermont for a decade. In 1985 when federal funding first became available for developing systems of care for children who are experiencing serious emotional disturbance and their families, the Department of Developmental and Mental Health Services took the lead:

- ■ establishing the State and Local Interagency Teams to serve this population;

- ■ defining the population to be served in Vermont;

- ■ creating a legal mandate (Act 264) for providing consolidated services plans for these children;

- ■ identifying the services these children need; and

- ■ finding the funds (private, federal, and state) to provide the services.

With *Access Vermont*, the Department of Developmental and Mental Health Services took a further lead:

- ■ reaching into Vermont communities for new partners for the system of care, including more families and domestic violence programs, youth service bureaus, and child care centers;

- ■ offering communities the incentive of new service funds for their regions if they worked and planned together;

- ■ expecting the partners/regions to identify and achieve mutually-desired outcomes;

- ■ providing ongoing feedback in the form of data and evaluation and technical assistance visits by a State Outreach Team; and

- ■ offering many opportunities for training.

This approach provided the basis for the success of *Access Vermont* and for strong development of the expanded Local Interagency Teams, which by and large became the Community Partnerships.

The *Access Vermont* Regional Plans did improve the services available locally for children and families in crisis, generally by increasing the capacity for crisis outreach, intensive home-based services, shelter and other forms of temporary respite, short-term follow-up, and flexible funding to meet the diverse needs of those in crisis. *Access Vermont* has been notably successful. The number of children admitted to State custody has declined significantly since the implementation of services began in the first quarter of State Fiscal Year 95. The *Access Vermont* service providers have been able to bring about this change, so far, by responding to families in crisis in a timely way, without waiting lists.

Overall, the number of children admitted to State custody during State Fiscal Year 97 was 18 percent lower than in State Fiscal Year 95. There was a 9 percent decline in the number of children admitted to State custody as a result or neglect and a 19 percent decline in the number of children admitted for delinquency. Even more impressive, and not counting "unmanageable " youth who can no longer enter custody at age 16 or 17 due to statutory change, there was a 30 percent decline in the number of "unmanageable" children admitted to State custody in State Fiscal Year 97 compared with State Fiscal Year 95.

In summary, through *Access Vermont*, the State of Vermont invited a wide group of people to become involved in planning regional services and then funded and monitored the outcomes of the services with them. This worked very well, producing cost-effective and popular services. The State agencies sponsoring the services were impressed with the outcomes and committed to continuing the services. The families and youth that received the services showed improvement and satisfaction. The people in the regions who designed and implemented the services and the other Community Partnership members advocated successfully with the Governor and Legislature (so far) for sustained funding beyond the end of the grant. Furthermore, the groups convened for planning the *Access Vermont* services frequently adopted other planning tasks as well when they moved to become the Community Partnership teams for their regions to improve a broad set of outcomes for children and families.

Lessons Learned

The system of care can be expanded/improved by focusing on regional planning which:

- involves collaboration across a broad spectrum of stakeholders (including consumers of services and key public policy decision-makers);

- focuses upon mutually-desired outcomes;

- is funded;

- receives ongoing attention from an interdisciplinary oversight committee;

■ is adjusted to respond to feedback data and training; and

■ keeps the public (including state officials and legislators) informed of its successes.

IMPLICATIONS FOR OTHERS

Any state can build its system of care by supporting regional planning and applying the lessons learned by Vermont. One particularly helpful mechanism is for a state to create a state outreach team of collaborating, interdisciplinary officials to meet regularly to oversee any regional planning and to provide ongoing, on-site, technical assistance.

Family Involvement

Project ACCESS
Alexandria, Virginia

Lori Godwin, Director of the Office of Management and Budget; Suzanne Chris, Director, Division of Social Services; Juliet Choi, Family Representative; Pam Fitzgerald Cooper, State Project Officer for ACCESS; Gene Shooter, Jr., Director, ACCESS; Keith Ewell, State Evaluator, ACCESS; Jackeline Bustos, Families For Families Coordinator, ACCESS; Nancy McCormick, Family Representative

Alexandria, Virginia, is an independent, full-service city (Virginia cities have no county affiliation) of approximately 16 square miles and with an estimated population of 118,000. With more than over 7,000 people per square mile, it is the most densely populated jurisdiction in Virginia and the 11th most densely populated in the country. The city has the highest percentage of African-Americans (21 percent) of any Northern Virginia jurisdiction and its Latino population (9 percent) has tripled over the past 10 years. Asian or Pacific Islanders (4 percent) and other minority groups (5 percent) are also represented in Alexandria. Thirty-two percent of Alexandria's children live in single parent households, compared to 20 percent in the adjacent Washington, D.C. metropolitan area. Just over 10 percent of the population is below the poverty level and approximately 14 percent of the Asian and African-American population and 12 percent of the Hispanic population can be considered poor. More than 19 percent of the City's population is younger than 21 years of age. Student enrollment in the public schools during Fiscal Year 1998 was 10,487, and more than 50 percent of this population was eligible for free or reduced price meals.

In September 1994, the city of Alexandria received a grant from the Center for Mental Health Services' Comprehensive Community Mental Health Services for Children and Their Families Program called *Project ACCESS*. The grant was designed to put in place an array of community-based, family-centered mental health and other services for youth with serious mental and/or behavioral disorders, and their families. We have experienced challenges and successes, and have learned many lessons in implementing *Project ACCESS*, particularly around involving families. Over time, we have clearly come to recognize the need to have families involved from the initial phases in developing our system of care.

Preserving and strengthening families is also a shared goal of the Commonwealth of Virginia and Alexandria as we seek to create a seamless child-and-family centered system of care. In 1992, the State began a major effort to reform service delivery and funding for children with serious mental and/or behavioral disorders and their families with the passage of the Comprehensive Services Act. In the same spirit, Alexandria has a long tradition of active citizen involvement on the policy boards

and commissions of numerous local government programs, including other programs for youth. Nonetheless, beyond these boards and commissions, there was no easy or family-friendly mechanism to include the families of the most at-risk children. Through the State's Comprehensive Services Act, local governments were mandated to create a multi-agency governance structure called Community Policy and Management Teams. In Alexandria, the local ordinance directs the Alexandria Community Policy and Management Team to include a City staff financial representative; the directors of child-serving agencies (health department, juvenile justice, mental health, schools, and social services); a private provider (vendor) representative; and two family representatives.

The ACCESS project was designed to increase active and full family involvement in all aspects of the system of care, with examples of how families should be involved. Those examples included family membership and participation in the Community Policy and Management Team of the Alexandria system of care, and in the family assessment planning teams (multi-agency teams that determine a plan of services for children and their families). Also, families would participate in advocacy by creating a strong parent support network. Another idea was to employ family companions from within the target neighborhoods, to help link families with services. In addition, the project was designed to help strengthen parents and families by providing training opportunities. All of these methods were envisioned to be important to overcoming barriers to greater levels of family involvement within the system of care.

The implementation of the grant, including the family involvement component, took much longer than anticipated. Since Alexandria had no family organizations at the inception of the project, an early goal of the Community Policy and Management Team was to establish a new entity to plan and implement approaches to family involvement, including linkages with state and national parent advocacy groups and outreach to families in Alexandria neighborhoods. However, before this could be done, the Project needed to have staff. Developing new job descriptions, determining appropriate salary ranges, recruiting, and hiring over 30 new positions into the city government took time and energy.

Not to further delay the implementation of family involvement, in the beginning of year three of the grant, the City authorized the solicitation of proposals from local community organizations to administer this component. A family representative on the Community Policy and Management Team was involved in the development of the request for a proposal and throughout the bid process. During this time, the ACCESS project director worked to establish a parent support group with interested parents and family caretakers who had been, or were currently involved with, the City's system of care. This group, initially called the ACCESS Family Support Group, began meeting regularly in February 1997. At the end of the bid period, the Community Policy and Management Team had received only one proposal from a community vendor, with whom they then entered into

negotiations. Negotiations were terminated in the Spring of 1997, when the Community Policy and Management Team was unable to reach an agreement with the vendor on several aspects of the proposal, including the total cost and a plan for the long-term sustainability of an independent family program. This process resulted in significant delays and was a point of frustration for the ACCESS Family Support Group. Throughout this period, the ACCESS Family Support Group actively identified barriers to family participation in planning meetings and training sessions by raising such issues as child care during meetings; transportation costs and access; and balancing home and work demands. Many of these issues presented unanticipated costs to local government employees involved in the ACCESS grant implementation which had to be addressed within existing local government reimbursement policies for child care, transportation, and meals. The Family Support Group also identified concerns for individual families navigating the system of care, who often found it to be confusing and intimidating.

The Community Policy and Management Team and the ACCESS project director met frequently with the ACCESS Family Support Group to resolve problems identified by the family group. As a result, the ACCESS Family Support Group proposed a revamped family involvement component that includes a revised budget for an advocacy coordinator position and part-time family advocates to assist families in understanding and navigating the system of care. The Community Policy Management Team decided to recruit a full-time family advocacy coordinator through the local government process rather than solicit new bids. Members of the ACCESS Family Support Group were involved in each stage of the hiring process including job descriptions, recruitment strategy, interviews, and final selection process.

The family advocacy coordinator for the family involvement project, now named Families For Families, was hired in February, 1998. Four part-time family advocates were also hired and began providing services in July 1998. With supervision from the family advocacy coordinator, the advocates provide support to families in a flexible manner, which includes meeting with individual families in their homes, during evenings or on weekends. The Community Policy and Management Team continues to recruit additional family advocates, particularly bilingual individuals. The team is optimistic that, as the Families For Families project grows, it will attract more families into an advocacy and peer-support role.

Throughout this process, the family involvement piece has continued to evolve to better serve Alexandria families. With leadership from the family advocacy coordinator, *Project ACCESS* has established *Project ACCESS*, a Project Advisory Council of family members, and a family support group called "You Are Not Alone." The Project Advisory Council currently consists of the core members of the former ACCESS Family Support Group as well as the family representative of the Community Policy and Management Team, who serves as the liaison between the Project Advisory Council and the Community Policy and Management Team. The Project Advisory Council

continues to provide valuable family input to the entire ACCESS project and to the Community Policy and Management Team. The family support group, "You Are Not Alone,"will provide peer-to-peer support for families with children with special needs. Although attendance has been low during the summer months, this group is expected to grow as the school year resumes.

Members of the Project Advisory Council attend Community Policy and Management Team meetings. Through their advocacy efforts, a second volunteer family representative position on the Community Policy and Management Team was authorized by City Council in May 1998. This action brings the policy committee to a nine-member committee, including two voting family representatives. Recruitment for this volunteer position continues. With the assistance of an outside consultant, the Families for Families project have also successfully completed a vital strategic planning process to define its mission and values. The Community Policy and Management Team also recently completed such a process. Work is underway to meld these two plans with the common goal of creating a unified and seamless child-and family-centered system of care.

There have been many lessons learned from the experiences in Alexandria. The local government administration identified new ways to build the basic components of family involvement, such as peer-to-peer support, grass roots advocacy, and policy-level participation. Early, active involvement of a family advisory board that included parents of limited means and/or children with special needs could have assisted City staff in addressing the issues which make it hard for parents to participate, such as child care, transportation, and meeting times, prior to program implementation. This early involvement may have also provided more opportunities to identify and recruit individuals from the community to be interested in serving as family advocates who would explain the system of care to new families in need of service, or at least to establish a peer-to-peer support group for families.

The structure of this grant as a part of the Alexandria City government presented unique challenges for recruiting and hiring staff and for involving families, which required unique solutions. Staff should have developed a recruitment/hiring plan that could have been put in place rapidly once the decision was made to bring the grant forward for final governing body approval. The overall plan for the grant needed the involvement of general government agencies, including the Personnel Department. The decision to seek proposals from community organizations for the family involvement component could have been more successful had staff solicited interest from likely community organizations prior to soliciting proposals. Also, it would have helped to be clear about the different roles of family groups, such as advocacy and policy interests, and peer-to-peer support. It is important to have both available in the community, but families may be more interested in one or the other. Most importantly, however, these experiences have given rise to new family leaders and advocates who are now actively involved and will continue to be an asset to the Alexandria system of care.

The 25 Kid Project: How Milwaukee Used a Pilot Project to Achieve Buy-In Among Stakeholders in Changing the System of Care for Children with Severe Emotional Problems

Milwaukee, Wisconsin

Bruce Kamradt, Project Director

From the onset of receiving a grant from the Center for Mental Health Services, the Milwaukee County Project Team focused on the mechanisms that would be necessary to design, develop and sustain a system of care for children with severe emotional problems and their families. The Project made some key decisions early in the design phase that would later help in targeting the population of seriously emotionally disturbed children who were of greatest concern to stakeholders in the system. We would build a structured program using managed care approaches, build service delivery around a case management system, and develop a Provider Network of Agencies offering a comprehensive array of services. In addition, we developed a mobile crisis response team to deal with the crisis needs of the children and their families and to gatekeep and avoid unnecessary inpatient psychiatric admissions. The Milwaukee Project also adopted the "wraparound" philosophy which focuses on identifying what families really need, building on their strengths, using both formal and informal supports, and providing services that are flexible and individualized.

The Milwaukee project established the name *Wraparound Milwaukee* in late 1994 to emphasize its design plan to wrap services around what families needed and to depart from the traditional categorical approach where "one size fits all." Between the Fall of 1994 and Spring of 1995, the Project embarked on an ambitious enrollment schedule. To help facilitate collaboration with other agencies, all referrals to the project were reviewed by the Wraparound Review and Intake Team which included representation from the Schools, Child Welfare, Juvenile Justice, Human Service Administration, Parents, and a Clinical Team from the Project. Since the national evaluation instruments had just been initiated and data would not be readily available for six months or longer, *Wraparound Milwaukee* was concerned about the availability of outcome data to key County stakeholders.

By the end of 1995, Wraparound had enrolled more than 175 children and their families. However, key County stakeholders in the system were not fully aware of the Project and how these new comprehensive, individualized and family-focused approaches to serving children with serious emotional disturbance and their families could be more effective than other approaches. Based on a "10 Kid Project"

that the Project Team had learned about in Columbus, Ohio, *Wraparound Milwaukee* began to look at the feasibility of a similar pilot project to truly test the Wraparound model. This would allow us to obtain outcome data that would build greater buy-in by some of the principal stakeholders (Child Welfare, Juvenile Probation, Judges, and Education) in the system of care. We chose to target the population of children that were of greatest concern to the stakeholders and public officials — children placed in residential treatment centers. This population was significant because of the escalating costs to the County associated with their care ($50,000 per year or more per placement). Follow-up studies also indicated poor results for this population (i.e., 40 percent never completed their placement and 60 percent of those who did complete the placement recidivated within six months of discharge). Our goal was to develop a pilot project for up to 25 youth, enroll them in Wraparound with a case manager, identify services headed by the families, access those services through the various agencies in the Provider Network, have a pool of flexible funding available for services not available in the Network, and offer the availability of the mobile crisis team to deal with crisis needs.

The specific design for the Project was to target children who currently had placements in residential treatment centers. The Project was to accept all 25 youths (no rejections) referred by the Child Welfare or Juvenile Justice Departments. These were children whom the Department had identified as not having any immediate plans for discharge and who the referring Social Workers believed could not be returned to the community without a very comprehensive and intensive community service plan (previously unavailable to them). The goal was to see if the Wraparound program and the services offered could result in:

- the child being returned to and maintained at home or in another community placement;

- improved outcomes for the children based on reports by parents and Case Managers and improved school attendance based on their pre-RTC placement experience;

- the children not presenting new public safety issues due to their return to the community (i.e., committing new delinquent acts); and

- plans that were less costly on a monthly average than the cost of the residential treatment placement.

The results of the Pilot Project would be documented at intervals of six months, one year and two years. The format chosen was to personalize each child's progress on one page and to write up the results in a manner that would be easy for Child Welfare, Juvenile Justice and Education officials, Judges, County Board Supervisors, and the media to read and understand. Specific categories chosen were the child's:

- prior problems and behavior at home and in the community;

- residential treatment center placement location and cost at time of enrollment;

- date enrolled in *Wraparound Milwaukee* and date discharged from the residential treatment center through *Wraparound Milwaukee*;

- case management agency assigned;

- services now being received through *Wraparound Milwaukee*;

- current status and accomplishments since enrollment;

- future plans and needs; and

- comparable cost of care in Wraparound to the residential treatment center placement.

While we were confident that the Pilot would be successful, we agreed with the Child Welfare Department that the results of the 25 Kid Project, good or bad, would be made available to the stakeholders. The severity of the problems and needs of this target group was evidenced by the fact that:

- Ten of 25 had histories of juvenile offenses prior to residential placement.

- Thirteen of 25 had Child and Adolescent Functional Assessment Scale (CAFAS) scores in the very high to extreme level of dysfunction and the remaining 12 had scores in the high level of dysfunction.

- The average length of their placements in residential treatment averaged 25 months.

- Almost all had poor school attendance prior to residential treatment placement.

On average, *Wraparound Milwaukee* case managers assembled child and family teams within two weeks of referral, and all children had Plans of Care within 30 days. Within six months of initiation of the Pilot, which occurred in May and June 1995, 17 of the 25 youth had been returned to the community. At the end of one year, 22 youth had moved back into the community with only three children needing to be placed back in an institutional setting. Of the 19 children placed in the community, 12 returned home or to a relative placement with seven going into foster homes. Only four of those children committed new delinquent acts within one year and none were serious enough to warrant supervision orders. All but one child was attending school on a regular basis based on reports from the Case Managers and teachers. The average cost of the community placements averaged $1,564 per month versus an average residential treatment cost of $4,700 per month.

The results of the 25 Kid Project were initially made available after six months to the principal stakeholders in the system. These stakeholders included:

- Director of Human Services

- Director of Child Welfare

- Chief Probation Officer

- School Superintendent and Special Education Director

- Juvenile Court Judges

- County Executive and County Board Supervisors, and

- Residential Treatment Center Supervisors

In early 1996, *Wraparound Milwaukee* staff worked with the County Public Information Officer to have stories about two of the children and families in the 25 Kid Project reported in the Milwaukee Journal/Sentinel. In the span of about three weeks, two stories were printed which heightened people's awareness of the Wraparound Project and results of the Pilot Project.

The residential treatment centers were very helpful in supporting the transition of the children back into the community. Some identified potential foster homes or provided some of the mix of services implemented in the community to support these children and their families. An outgrowth of the 25 Kid Project was the initiation of monthly meetings among all the residential treatment facility directors and Project staff. Initiated in March 1996, these meetings are an important component in achieving buy-in to alternative programming for children in residential care.

The Director of Child Welfare also became a stronger supporter of Wraparound due in part to the outcome of the 25 Kid Project. Not pleased with the cost and poor residential care outcomes, the Director was easily sold on the individualized, comprehensive and flexible services available through *Wraparound Milwaukee*. His support was ultimately crucial in the expansion of the Pilot and in providing funding support from Child Welfare.

The 25 Kid Project was also linked with a proposal to the Director of Human Services and County Executive to expand the Pilot Project from the original 25 youth to the entire population of 350 children currently placed in residential treatment centers. The plan was to incrementally enroll children currently in residential facilities, as well as divert children from going into residential care. Over 18-24 months the entire population of children in residential care and their families would be enrolled in *Wraparound Milwaukee*. Results of the 25 Kid Project were written into the proposal and eventually into the reports going to the Health and Human Needs Committee of the County Board. Working with the Director of Child Welfare and our Managed Care Consultant, the case rate to be paid by Child Welfare to *Wraparound Milwaukee* was established in March-April 1996 and negotiations with the State on a capitated Medicaid payment were

moved forward. The expansion of the 25 Kid Project, which we now call Wraparound II, was officially initiated in May 1996. By the end of 1997 we had served more than 400 children and their families.

This brief paper cannot address all of the challenges and difficulties presented in operating the Pilot Project, nor the complexities of taking it to scale. The information does, however, demonstrate how a small pilot project targeted at a population of children whose complex emotional, behavioral, and mental health needs have not been met in the existing system of care can be used as a catalyst for change. It can draw in the more skeptical and reluctant stakeholders whose participation is essential for changing the system of care.